University Health and Urgent Care

PATIENT INFORMATION

LAST NAME: _____ **MIDDLE INITIAL:**_____ **FIRST NAME:**_____

ADDRESS: _____

TELEPHONE: (____) _____ - _____

Can we leave a voicemail regarding NORMAL results? (Y) (N)

EMAIL ADDRESS:_____@_____.com

Can we contact you in future via this email address? (Y) (N)

DATE OF BIRTH: __/__/____ **AGE:** ____ **MARITAL STATUS: S M D W (CIRCLE) SEX: M F**

OCCUPATION: _____ **EMPLOYER:** _____

REASON FOR VISIT: _____

INSURANCE HOLDER INFORMATION

☐ **Check here if you are the policy holder**

☐ **Check here if the policy holder's address is the same as above**

NAME OF POLICY HOLDER:_____

POLICY HOLDER'S ADDRESS (if different from above):_____

POLICY HOLDER'S DATE OF BIRTH (if different from above):_____

EMERGENCY NOTIFICATION

IN CASE OF EMERGENCY, NOTIFY: _____

TELEPHONE: (____) _____ - _____

RELATIONSHIP: _____

TODAY'S DATE:__/__/____

University Health and Urgent Care

ASSIGNMENT OF INSURANCE BENEFITS AND NOTICE OF PRIVACY PRACTICES AND THE RELEASE OF INFORMATION

If your insurance is an HMO, POS, or MC plan and University Health and Urgent Care is not listed as your primary care provider, I the undersigned understand and agree that I am fully responsible for any out of network and deductible payments that are not covered by your insurance.

The, undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as through the undersigned had personally signed the particular claim.

I understand and agree that should the insurance card I present today be invalid, expired, incorrect in any way, or not the appropriate card for my current insurance, that I will be personally financially responsible for any charges incurred as a result of such error. I also agree that it is my responsibility to present the correct insurance card at the time of each visit I further agree to accept responsibility for any bills incurred that are denied by my current Insurance company for any reason including timely filing as a result of my failing to present an appropriate insurance card or presenting inaccurate or incorrect personal information, including old or invalid insurance cards, licenses or other identifying information.

I also understand and agree that Is it within the rights of University Health and Urgent Care to collect any outstanding charges by billing me personally through any collection method including phone, mail or collection agency. Should such delinquent accounts remain unpaid after 90 days, University Health and Urgent Care or its agents may forward such accounts to a collection agency and that such accounts may be reported to a national collection bureau. I hold University Health and Urgent Care, its agents or assignees harmless for any and all damages resulting from such action.

I understand and agree that if I do not have insurance, I will be responsible for all charges incurred today due in full at the end of my visit unless other arrangements were made prior to my visit.

I (name)_____hereby authorize my insurance carrier to pay and hereby assign directly to University Health and Urgent Care all benefits, if any otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to University Health and Urgent Care, will be credited to my account. in accordance with the above said assignment.

Your signature below acknowledges that you read agree to the above and that you have received the Notice of Privacy Practices and the Release of Information.

If the patient is a minor (under the age of 18), please sign on their behalf.

Print name: _____ **Signature:** _____

Date: ____/____/____

RELEASE OF INFORMATION

Telephone number where we can best reach you: _____

May we leave a voicemail message at the above number regarding NORMAL test results? Yes / No

We will always speak to you directly about ABNORMAL test results.

Please list below the name(s) and phone number(s) and relationship to you of individuals with whom we may discuss your medical information.

	NAME	PHONE NUMBER	RELATIONSHIP
1.			
2.			

Please list below the name of your primary doctor (s) and phone number(s) with whom we may discuss your medical information.

	NAME	PHONE NUMBER	RELATIONSHIP
1.			
2.			

Your signature below acknowledges that you have received the Notice of Privacy Practices and the Release of Information.

If the patient is a minor (under the age of 18), please sign on their behalf.

☐ **Patient is under 18**

Print name: _____ **Signature:** _____

Date: _____

If you are a new patient or have been treated by another physician, please complete a medical release form to have medical records forwarded to University Health and Urgent Care so we can provide the best care for you.

ALLERGIES

- ☐ I have no drug allergies
- ☐ I have a latex allergy
- ☐ List medication allergies and the type of reaction you had

_____
_____
_____
_____

IMMUNIZATIONS

Vaccination	Year / Never
Pneumonia (pneumovax)	_____/_____
Tetanus booster (Tdap)	_____/_____
TB skin test (PPD)	_____/_____
Hepatitis B vaccine	_____/_____
Hepatitis A vaccine	_____/_____

PREVENTATIVE CARE

Test or procedure result/Never	Date and
Colonoscopy	_____/_____
Bone Density Test (DXA)	_____/_____
Cholesterol Test	_____/_____
PSA (prostate cancer test)	_____/_____
Pap smear	_____/_____
Mammogram	_____/_____
HIV test	_____/_____
Hepatitis C screen	_____/_____
Varicella (chicken pox)	_____/_____
Singles (Zostavax)	_____/_____

OTHER HEALTH ISSUES

Do you feel unsafe, or have you been harmed in a physical, emotional or sexual manner, in any relationship or recent encounter? Yes / No If yes, please describe:

_____
_____
_____

MEDICATIONS List with doses. Include contraceptives, vitamins, supplements, etc. Attach list if needed.

- ☐ None

_____
_____
_____
_____
_____

FAMILY HISTORY (check all that apply)

	Alcohol abuse	Breast cancer	Ovarian cancer	Prostate cancer	Diabetes	Heart disease	High cholesterol	Hypertension	Mental Illness	Other
Mother										
Father										
Sister										
Brother										

YOUR MEDICAL CONDITIONS
(check all that apply)

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer - type _____
- ☐ Clotting disorder
- ☐ Congestive heart failure
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Emphysema / COPD
- ☐ Gastroesophageal reflux disease (GERD)
- ☐ Glaucoma
- ☐ Heart murmur
- ☐ HIV/AIDS
- ☐ High cholesterol
- ☐ Hypertension / high blood pressure
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Kidney Disease
- ☐ Myocardial infarction
- ☐ Nerve/muscle disease
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Substance abuse
- ☐ Thyroid disease
- ☐ Other _____

Have you ever had a blood transfusion?
No / Yes – approximate dates: _____

HABITS AND ACTIVITIES (please circle)
Do you use tobacco? No / Yes

If in the past – how many years since you quit
_____

If yes, what form? _____
If yes, have you tried to quit? Yes / No
If yes, would you like to quit? Yes / No

Do you drink alcohol? No / Yes / In the past
If yes, how many drinks per week?
_____

SURGICAL HISTORY
(check all that apply)

- ☐ Appendectomy
- ☐ Brain Surgery
- ☐ Breast surgery
- ☐ CABG
- ☐ Cholecystectomy
- ☐ Colon surgery
- ☐ Tonsillectomy
- ☐ Thyroid surgery
- ☐ Lung surgery
- ☐ C – section
- ☐ Eye surgery
- ☐ Fracture surgery
- ☐ Hernia repair
- ☐ Hysterectomy
- ☐ Joint surgery
- ☐ Bunionectomy
- ☐ Varicose vein surgery
- ☐ Prostate surgery
- ☐ Weight reduction surgery
- ☐ Spine surgery
- ☐ Tubal ligation
- ☐ Valve replacement
- ☐ Vasectomy
- ☐ Vascular surgery
- ☐ Cardiac stent
- ☐ Bladder surgery
- ☐ Other:

_____

Do you use any recreational drugs? No / Yes

If yes, please describe: _____

_____

Do you exercise regularly? No / Yes
If yes, what kind of exercise? _____

_____

How often? Daily / Weekly / Monthly

COVI-19 PRE-SCREENING QUESTIONNAIRE

Question	Y/N	Explanation
Have you or a member of your household had any of the following symptoms in the past 30 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever, temperature at or greater than 100 degrees Fahrenheit? (If yes, obtain information about who had the symptoms, what the symptoms were, when the symptoms started, when the symptoms stopped.)		
Have you or a member of your household been tested for COVID-19?		
Have you or a member of your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days? (If yes, explain)		
Have you or a member of your household traveled elsewhere in the U.S. or abroad in the past 30 days? (If yes, explain)		
Have you or a member of your household traveled on a cruise ship in the past 30 days? (If yes, explain)		
Are you or a member of your household healthcare providers or emergency responders?		
Have you or a member of your household cared for an individual who is in quarantine or is a presumptive		
Do you have any reason to believe you or a member of your household has been exposed to or acquired COVID-19? (If yes, obtain information about the believed source of the potential exposure and any signs that the person acquired the virus.)		
Have you received vaccination for COVID-19		

I certify that I understand the above questions, and that my answers to the above questions were true and accurate at the time I provided the answers and are true and accurate at the time I signed below.

_____

Signature

_____

(Spell out name)

Date: