University Health and Urgent Care

PATIENT INFORMATION

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

ADDRESS: _____

MOBILE: (___)_____-_____ **TELEPHONE:** (____)_____-_____

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

May we send a text message with clinic updates and/or secure links to test results?
You will have the option to opt-out at any time and will not receive more than two per month.
(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/Advanced Perioperative Medicine 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 my dependents and that I will be bound by this signature as though 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, 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 it is within the rights of University Health and Urgent Care/Advanced Perioperative Medicine 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 60 days, University Health and Urgent Care/Advanced Perioperative medicine 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/Advanced Perioperative Medicine, 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 hereby authorize my insurance carrier to pay, and hereby assign directly to University Health and Urgent Care/Advanced Perioperative Medicine, all benefits, if any otherwise payable to me for the facility's 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: ____/____/____

University Health and Urgent Care

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.	_____		

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.

YOUR MEDICAL CONDITIONS (check all that apply)

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

HABITS AND ACTIVITIES (please circle your answer)

Do you use tobacco? No / Yes what form? _____
If in the past – how many years since you quit? _____
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? _____

Have you ever used recreational drugs? No / Yes
If yes, please describe: _____
_____

Do you get regular exercise? No / Yes
If yes, what kind of exercise? _____
How often? (please circle) - Daily / Weekly / Monthly

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
- ☐ Prostate surgery
- ☐ Weight reduction surgery
- ☐ Spine surgery
- ☐ Tubal ligation
- ☐ Valve replacement
- ☐ Vasectomy
- ☐ Vascular surgery
- ☐ Cardiac stent
- ☐ Bladder surgery
- ☐ Other: _____

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)	_____/_____
Hepatitis B vaccine	_____/_____
Hepatitis A vaccine	_____/_____
Varicella (chicken pox)	_____/_____
Shingles (Zostavax)	_____/_____
Tetanus booster (Tdap)	_____/_____

OTHER HEALTH ISSUES

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

PREVENTATIVE CARE

Test or procedure	Date and result/Never
Colonoscopy	_____/_____
Bone Density Test (DXA)	_____/_____
Cholesterol Test	_____/_____
PSA (prostate cancer test)	_____/_____
Pap smear	_____/_____
Mammogram	_____/_____
HIV test	_____/_____
Hepatitis C screen	_____/_____
TB skin test (PPD)	_____/_____

MEDICATIONS

List with doses. Please include contraceptives, vitamins, supplements, etc. Attach list if needed.

_____
_____
_____
_____
_____
_____
_____
_____
_____

SPECIALISTS INVOLVED IN YOUR CARE

Primary Care Doctor Name, address, and phone number: _____
_____
_____

Pharmacy Name, address, and Phone numbers:
_____
_____

Others:
_____
_____

FAMILY HISTORY (check all that apply

	Alcohol Abuse	Breast Cancer	Ovarian Cancer	Prostate Cancer	Diabetes	Heart Disease	High Cholesterol	Hypertension	Mental Illness
Mother									
Father									
Sister									
Brother									
Daughter									
Son									