

Medical History and Authorization to Treat

Legal Name (Last, First, MI): _____ Preferred Name: _____

DOB: _____ Student ID: _____ Cell Phone: _____ Are you a minor? (under 18) _____

Gender: _____ If your sex-assigned-at-birth differs from your gender, please specify: _____ Pronouns: _____

When and where did you attend high school? _____

List any allergies you have (medication, foods, pollen, etc.), including your allergic reaction: _____

Do you use any of the following: Alcohol Marijuana Tobacco Other drugs

If you are a smoker, are you ready to quit? Yes No

List any surgeries you have had: _____

List any overnight hospital admissions, including psychiatric: _____

List any medications (including over-the-counter) and/or supplements you take regularly: _____

Have you received the usual immunizations required by public schools? Yes No Not sure

Are you under the care of a healthcare professional for any chronic or ongoing illness (for example, diabetes, asthma, heart problems, epilepsy, etc.)?

Yes No If yes, please list: _____

Has any immediate biological family (parents, siblings) experienced the following:

Heart disease Blood clotting disorders Tuberculosis Cancer Sudden death Mental health disorder

Other: _____

Have you ever had any of the following:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Physical or emotional abuse | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma/lung disease | <input type="checkbox"/> Autoimmune Disorder |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Blood clotting disorder | <input type="checkbox"/> Cancer | <input type="checkbox"/> Dengue fever |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Dermatological problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Fainting or loss of consciousness | <input type="checkbox"/> Gynecological disorder | <input type="checkbox"/> Head injury/concussion | <input type="checkbox"/> Heart problem/heart murmur |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Hives/urticarial/anaphylaxis | <input type="checkbox"/> Kidney disorder |
| <input type="checkbox"/> Malaria | <input type="checkbox"/> Migraines | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> POTS |
| <input type="checkbox"/> Psychiatric/psychological disorder | <input type="checkbox"/> Seizures | <input type="checkbox"/> Stomach/intestinal disorder | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Typhoid fever | <input type="checkbox"/> Vision or hearing problems | <input type="checkbox"/> Tuberculosis | |

Other: _____

If you would like to give more detail on any of your answers, please do so here:

Emergency Contact (Please indicate the nearest relative or friend that we may contact on your behalf in the event of an emergency):

Name: _____ Relationship: _____ Phone: _____

Authorization for Treatment (if patient is over 18 years of age)

I do hereby consent, authorize, and request Student Health and Wellness Center personnel, physician, mental health representative, other medical representative to whom referral is made, and/or contracted staff (including massage therapists) to conduct treatment and/or provide services which they may deem advisable in the event I should require medical or wellness care while a student at the University of North Texas. I also agree to pay all charges incurred at the time of service.

Authorization for Treatment (if patient is under 18 years of age)

I do hereby consent, authorize, and request Student Health and Wellness Center personnel, physician, mental health representative, other medical representative to whom referral is made, and/or contracted staff (including massage therapists) to conduct treatment and/or provide services which they may deem advisable in the event I should require medical or wellness care while a student at the University of North Texas. I also agree to pay all charges incurred at the time of service.

Patient Long-Term Signature Authorization

I hereby authorize the release of any medical information in order to process my medical insurance claim to the UNT-endorsed student insurance policy. I authorize payment of medical benefits to the Student Health and Wellness Center. I also authorize the Student Health and Wellness Center to release medical information as necessary for continued treatments. The person giving this authorization may revoke such authorization at any time in writing. Photocopies of the authorization may be used in place of the original.

I understand the Student Health and Wellness Center only files insurance claims to the UNT-endorsed student insurance policy.

Eligibility for Services

Students who have paid the medical services fee and are enrolled are allowed access to the Student Health and Wellness Center.

Students who are no longer enrolled at UNT are no longer eligible to use the services provided at the Student Health and Wellness Center; however, there is an opportunity for continuing students to be seen at the Student Health and Wellness Center during the summer by paying a charge for the visit.

Students are allowed to have one follow-up visit to provide continuity of care from a previous medical visit during the first semester of non-enrollment by paying an associated charge. Additional follow-up visits will only be scheduled if they are deemed medically necessary by the provider.

Anticipated Date of Graduation: _____

Address Update Information

It is the responsibility of the student to provide accurate, updated address information at all times to the University. Failure to do so constitutes a breach of the Student Code of Conduct. Any student who changes their address must notify the Registrar's Office immediately or update their information at my.unt.edu.

By signing this document, I acknowledge that I understand all of the above information as it is written.

Signature: _____

Date: _____

Witness: _____

Date: _____