Student Health *and* Wellness Center

1155 Union Circle #305160
Denton, Texas 76203-5017
(940) 565-2333
Fax: (940) 369-7042

List Allergies to Medications
_____
_____
_____

ID# _____
SS# _____

Name_____
Last First MI

Race _____ Gender _____ DOB _____
Parents/Legal Guardian/Spouse_____ Tele (____)_____
Address/City_____
Mother's maiden name_____ City/State of **Patient's Birth**_____
Personal usage of: Alcohol_____Drug_____Tobacco_____
Contraceptive Used_____
Routine Medication_____
Do you have a chronic condition? _____ If so, who is your treating medical provider? _____
Height_____Weight_____
Do you currently have or ever had any of the following? Current - C; Past - P

_____Emotional/Mental Illness
_____Depression/Sadness
_____Anxiety/Worry
_____Eating Disorder
_____Excessive Alcohol use
_____Illicit Drug use
_____Recurrent headaches
_____Migraine headaches
_____Convulsions/Seizures/Epilepsy
_____Diminished Hearing
_____Dizziness/Fainting
_____Visual Disorder
_____Congenital Heart Disease
_____Heart Disease/Murmur
_____High Blood Pressure
_____Asthma
_____Persistant Cough
_____Food/Pollen Allergies
_____Pneumonia

_____Colitis or Colon problems
_____Frequent Indigestion
_____GERD (Acid Reflux)
_____Stomach Ulcer
_____Gall Bladder
_____Hepatitis
_____UTI
_____Kidney Disease
_____Diabetes
_____Thyroid Disorder
_____Anemia
_____Blood Disorder/Disease
_____Cancer
_____Chicken Pox
_____Infectious Mononucleosis
_____STD
_____Measles
_____Mumps
_____HIV

_____Rheumatic Fever
_____Tuberculosis
_____Typhoid Fever
_____Malaria
_____Arthritis
_____Chronic Back Problems
_____Chronic Skin Disorder
_____Unusual Childhood Illness
_____Other_____

Family History
_____Blood Disorder/Disease
_____Cancer
_____Diabetes
_____Epilepsy/Seizure
_____Heart Disease
_____High Blood Pressure
_____Tuberculosis
_____Mental Illness
_____Other_____

Have any of the above affected your ability to function or cope?___Yes ___No
Have you ever been hospitalized or had surgery in the past?___Yes ___No (List)_____,
_____, _____, _____

IMMUNIZATIONS HISTORY:
DT_____ HepB_____ MMR_____ Polio_____ Meningitis_____ Tdap_____ Varicella_____
Date Date Date Date Date Date Date

I hereby certify the above history is complete and true.

_____
Signature of Patient / Parent / or Legal Guardian Date

UNT Provider Reviewed_____ **Date**_____

See Other Side

UNT Authorization and Permission to Treat

Authorization for Treatment (if patient is over 18 years of age)
I do hereby consent, authorize, and request Student Health and Wellness Center personnel, and/or physician and/or mental health representative and/or other medical representative to whom referral is made, to conduct treatment which they may deem advisable in the event I should require medical 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, and/or physician and/or mental health representative and/or other medical representative to whom referral is made, to conduct treatment which they may deem advisable in the event my son/daughter should require medical care while a student at the University of North Texas. I also agree to pay all charges incurred at the time of service.

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

Patient Long-Term Signature Authorization
The UNT Student Health and Wellness Center is aware that other departments on campus no longer require the use of you social security number. Please be advised that failure to provide your social security number to the Student Health and Wellness Center will significantly hinder the services available to you (including, but not limited to, lab work, x-rays, pharmacy and education). Your social security number will ONLY be used to provide and access medical services.

I am aware the UNT Student Health and Wellness Center follows federal HIPAA guidelines in protecting my information. The Notice of Privacy Practices (NPP) describes my rights as a patient and how the SHWC may use my Protected Health Information (PHI) for treatment, payment, and operation. At any time, I may request a copy of the SHWC NPP from the Medical Records Department.

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 UNT Student Health and Wellness Center. I also authorize the Student Health and Wellness Center to release medical information as necessary for continuing treatments. The person giving this authorization my revoke such authorization at any time in writing. Photocopies of the authorization may be used in place of the original.

Eligibility for Services:
Students who have paid the medical service fee and are enrolled are allowed access to the SHWC.

Students who are no longer enrolled at UNT are no longer eligible to use the services provided at the SHWC. However, there is an opportunity for continuing students to be seen at the SHWC during the summer by paying a fee 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 fee. 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 students 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 information at my.unt.edu. (UNT Policy Number: 18.1.4)

By signing this document, I acknowledge that I understand all of the above information as it is written. Also, I hereby certify the above history is complete and true.

Signature: _____ Date: _____

Witness: _____ Date: _____