UNIVERSITY OF
NORTHERN COLORADO

University Health Clinic Demographic Form

Name in Use: Last, First	**Legal Name if Different**: Last, First (for insurance purposes only)	**Date:**
Pronouns in Use: _____ **Gender:** _____ **Sex assigned at birth:** ☐ **Male** ☐ **Female** (for medical and insurance purposes only)	**Bear Number:** _____ **Social Security #:** _____	**Date of Birth:** _____ _____ **MM/DD/YYYY** **Age** **Optional: Race/Ethnicity:** _____ **Optional: Sexual Orientation:** _____ **Optional: Veteran Status** _____
Address: _____ **Street** **City/State** **Zip**		
Phone:	**Email:**	**Country of Birth: Optional** ☐ **US** ☐ **Other:**

Emergency Contacts:

1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

What name should we use to refer to you if/when we need to speak with your emergency contact: _____

Insurance Company Name:	**Guarantor's Name (person you are insured under):**	**Policy holder Date of Birth:** _____ MM/DD/YYYY
Policy Holder SS#:	**Policy Holder Phone #:**	**Policy Holder Address:** _____ **Street** **City/State** **Zip**
Policy Number:	**Group #:**	**Effective Date:**

Note: This information will not be used for any purpose other than to bill health insurance for applicable services received at this clinic.

MEDICAL OR HEALTH CONCERNS – Please check conditions/diseases you have had. If NONE apply, check this box:

Acne		Diabetes Mellitus		Kidney Disease		Systemic lupus erythematosus	
Anemia		Eating disorder – anorexia, bulimia		Migraines or recent Headache		Thyroid disorder	
Asthma		Eye Disease		Multiple sclerosis		Treated for alcohol or drug use	
Arthritis		Hay fever/seasonal allergies		Obesity		Tuberculosis	
Anxiety		Heart Disease		Peptic Ulcer		Treatment for active Tuberculosis	
Bleeding Disorder		Hepatitis		Pelvic Infection		Past Positive Tuberculin Skin Test (Mantoux)	
Blood disorder/clots		High Blood Pressure		Phlebitis/blood clots		Inflammatory bowel disease/Crohn's ulcerative colitis	
Cancer/malignancy		High Cholesterol		Polio		Rheumatic Fever	
Cerebral Palsy		Gall Bladder Disorder		Prostatitis		Seizure Disorder/Epilepsy	
Chicken pox		Chronic Bronchitis		Emphysema		Urinary Disorder/Infections	
Depression		Immune Compromised		Skin Disorder		Substance Use Disorder	
Other:							

Name in Use: Last	Name in Use: First:	Bear Number:

Do you have an illness or condition not listed above, for which you are now being treated: ☐ Yes ☐ No If yes, please specify:

_____

_____

List Date(s) and reason(s) for any hospitalizations and/or surgeries:

_____

_____

Do you have any chronic medical problems? ☐ Yes ☐ No If yes, please have your physician write a medical summary and attach to this form

PERSONAL HEALTH HISTORY:

Do you have any drug allergies ☐ Yes ☐ No If yes, please specify:

Are you currently taking daily medication? ☐ Yes ☐ No If yes, please list the medication and reason for use:

_____

_____

_____

Do you take allergy desensitization shots: ☐ Yes ☐ No

If yes, do you plan to receive your allergy shots at UNC? ☐ Yes ☐ No

(If you answered yes, please call the health center at 970-351-2412 for instructions)

FAMILY MEDICAL HISTORY

Check all diseases that apply to your family: ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Cancer ☐ Stroke ☐ Blood Clots ☐Asthma ☐ Other:

DISABILITY

If there are any disabilities, health conditions, or support needs that may require accommodations or services, please specify: ☐ Vision ☐ Emotional/Mental Health ☐ Hearing ☐ Learning ☐ Mobility

☐ Other: _____

Please describe accommodations or supports you may need:

_____

_____ I authorize UNC SHC to share information regarding my disability with the appropriate University Office to support my success at UNC. ☐ Yes ☐ No

Cultural or Religious Considerations:

Are there cultural, spiritual, or religious beliefs that may impact your care?

Yes or No. If Yes, please describe: _____

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UNC University Health Clinic General Consent for Medical Treatment

Patient name in use: _____

DOB: _____

Bear #: _____

I consent to allow the providers of the University Health Clinic to perform necessary medical examinations and tests to diagnose and treat my health conditions.

I understand that “providers” include, but are not limited to, physicians and other healthcare providers that are my treating and consulting physicians, radiologists, other specialists, and any advanced practice providers whom these physicians employ.

I have the right to have a chaperone present when I am with my provider.

I have the right to discuss any treatment with my provider. I am encouraged to ask questions about any concerns I have.

I understand that if additional testing or invasive procedures are needed, I will be asked to read and sign additional consent forms.

This consent is valid until I revoke it in writing.

Print name: _____

Date: _____
Signature: _____

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How Would You Like Us to Contact You?

Please indicate below the ways in which we have your permission to inform you of test results or other personal healthcare information.

(Sending or receiving Private Health Information via online channels such as email carries inherent risks to the privacy and security of that information).

Name in use: _____ **DOB:** _____ **BEAR#**

_____

□ **BY MAIL**:

Address: _____

City: _____ State: _____ Zip: _____

□ **BY PHONE**:

Home Phone Number: _____

Okay to leave detailed recorded message? □ YES □ NO

Cell Phone Number: _____

Okay to leave detailed recorded message? □ YES □ NO

□ **BY EMAIL**:

Email Address: _____

Alternate Email Adress:

_____

Names of other individuals to whom we may give information: _____

_____

_____

Acknowledgment of Receipt of Privacy Practices

I have received a copy of the University of Northern Colorado Notice of Privacy Practices with an effective date of 7/22/08.

Signature of Patient: _____

Date: _____

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Assignment of Benefits: Financial Agreement

Patient Name: _____

I hereby give lifetime authorization for payment of insurance benefits be made directly to University Health Clinic and any assisting physicians, for services rendered.

I understand that I am financially responsible for all charges whether they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney fees.

I hereby authorize this healthcare provider to release all the information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____

Method of payment □ cash □ check □ credit card

INSURANCE DISCLOSURE

I understand that I am ultimately responsible for any incurred charges, co-payments, or coinsurances for my treatment if my insurance does not cover such treatment. I understand that I am responsible for co-payments at the time of service.

I further understand that failure to present my insurance card at time of service may result in self-pay until a copy of my card has been submitted.

I understand that I am responsible for verifying my insurance benefits limitations for my treatment as well as verifying whether applicable treatments will require authorization prior to services rendered. I understand that quotation of benefits and authorizations are not a guarantee of payment from my insurance company.

Patient Signature: _____
Date: _____

The University Health Clinic is intended for the care of currently enrolled students and employees.

NOTE: After graduation or withdrawal from classes you are no longer eligible to use the Health Clinic.

The Health Clinic can provide care for the most common types of acute illness and injury. However, if at any time you are referred off campus to a specialist, Urgent Care, or hospital Emergency Room, you are responsible for all those charges. If you have any chronic illness, it is highly suggested that you obtain care from a local provider who is available to you 24 hours a day.

INITIAL ___ I hereby authorize the University Health Clinic to release to my insurance company all information they may require concerning my care.

INITIAL ___ Assignment of Benefits; I authorize the payment of any benefit from my insurance carrier directly to the University Health Clinic.

Worker's Compensation and Auto Related Injuries

The University Health Clinic does not provide any care related to Worker's Compensation or auto related injuries. You will need to contact your employer or your auto insurance company to proceed.

EVERYONE COMPLETE BELOW:

Signature: _____ Date: _____

HEALTH CLINIC PLACE LABEL HERE