UNIVERSITY OF NORTHERN COLORADO
HEALTH HISTORY

RETURN FORM TO:
UNC Student Health Center
Cassidy Hall
Campus Box 37
Greeley, CO 80639

NAME LAST	FIRST	MI	
BEAR #	SS#	DATE	

DATE OF BIRTH (mm/dd/yy) _____	AGE	GENDER ☐ M ☐ F ☐T	COUNTRY OF BIRTH ☐ U.S. ☐ Other (specify)

ADDRESS #1	CITY/STATE/ZIP
HOME PHONE	MOBILE PHONE

EMERGENCY CONTACT

Name_____Relationship_____Phone(H)_____(W)_____

INSURANCE INFORMATION _____ _____
INSURANCE COMPANY NAME GUARANTOR'S NAME: (Parent you are insured under)

_____ _____
Policyholder D.O.B. Policyholder SS#

Insured parent's address _____
Address City State Zip

Insured parents phone number _____

POLICY # _____ GROUP # _____ EFFECTIVE DATE _____

(Note: This information will not be used for any purpose other than to bill applicable health insurance for services received at the UNC Student Health Center).

MAJOR FIELD OF STUDY _____ STATUS

☐ Full time Undergraduate ☐ Part-time ☐ Full time Graduate - Dept._____

ENTERING SEMESTER ☐ Fall 2013 ☐ Spring 2014

☐ Fall 2014 ☐ Spring 2015

PREVIOUS RELATIONSHIP WITH THE UNIVERSITY OF NORTHERN COLORADO

☐ Previous student Dates Enrolled _____

This information is strictly for the use of the Student Health Center and will not be released to anyone without your knowledge and written consent.

PERSONAL HEALTH HISTORY

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

_____

Are you currently taking daily medications? ☐ Yes ☐ No If yes, please list the drugs and reason:_____

_____

Do you take allergy desensitization shots? ☐ Yes ☐ No

If so, do you plan to receive your allergy shots at UNC? ☐ Yes ☐ No If yes, please contact SHC for advice. (970) 351-2412

UNC

UNIVERSITY OF NORTHERN COLORADO
HEALTH HISTORY - continued

NAME LAST	FIRST	MI	BEAR #

MEDICAL OR HEALTH CONCERNS—Please check conditions/disease you have had. If NONE apply, check this box. ☐

	Yes
Acne	☐
Anemia	☐
Asthma	☐
Arthritis	☐
Anxiety	☐
Bleeding disorder	☐
Blood disorder/clots	☐
Cancer/malignancy	☐
Cerebral palsy	☐
Chicken pox	☐
Chronic bronchitis/emphysema	☐
Depression	☐

	Yes
Diabetes mellitus	☐
Eating disorder: anorexia nervosa, bulimia	☐
Eye disease	☐
Hay fever/seasonal allergies	☐
Heart disease	☐
Hepatitis	☐
High blood pressure	☐
High cholesterol	☐
Gallbladder disorder	☐
Inflammatory bowel disease/ Crohn's, ulcerative colitis	☐

	Yes
Immune Compromised	☐
Kidney Disease	☐
Migraine or recurrent headache	☐
Multiple sclerosis	☐
Obesity	☐
Peptic ulcer	☐
Pelvic infection	☐
Phlebitis/blood clot	☐
Polio	☐
Prostatitis	☐
Rheumatic fever	☐
Seizure disorder (epilepsy)	☐

	Yes
Skin disorder	☐
Systemic lupus erythematosis	☐
Thyroid disorder	☐
Treatment for alcohol or drug use	☐
Tuberculosis	☐
Treatment to prevent tuberculosis	☐
Treatment for active tuberculosis	☐
Past positive tuberculin skin test (Mantoux)	☐
Urinary disorders/infections	☐
Other (specify) _____	

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

FAMILY MEDICAL HISTORY

Check all diseases that apply to your family: ☐ Heart disease ☐ Hypertension ☐ Diabetes ☐ Cancer ☐ Blood clots ☐ Stroke ☐ Asthma

☐ Other (please specify)_____

DISABILITY

If there are any other aspects of your health that have caused problems for you or that might require special arrangements at the University of Northern Colorado, please specify: ☐ Vision ☐ Emotional/mental ☐ Hearing ☐ Learning ☐ Mobility ☐ Other:_____

Please explain disability and special consideration needed:_____

I authorize you to share information regarding my disability with the appropriate University offices. ☐ Yes ☐ No

STUDENT'S SIGNATURE: **DATE:**

UNIVERSITY of
NORTHERN COLORADO

How Would You Like Us To Contact You?

Your healthcare information is private and we will protect it! Please indicate below the ways in which we have your permission to inform you of test results or other personal healthcare information.

Name of patient: _____ 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

Names of other individuals to whom we may give information:

_____

_____

_____

☐ OTHER:_____

_____

_____

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:**

_____ _____

UNIVERSITY of
NORTHERN COLORADO

STUDENT HEALTH CENTER
Cassidy Hall, 1901 10th Avenue
Greeley, CO 80639
Phone (970) 351-2412 Fax (970) 351-2427

Student's Name (Please Print) _____ Bear Number _____ Date of Birth _____

CONTACTS IN EVENT OF EMERGENCY

EMERGENCY
CONTACT NAME _____
CITY STATE

DAY PHONE (_____) _____ EVENING PHONE (_____) _____

_____ (_____) _____
Person to Be Contacted if Above Not Available Phone

CONSENT FOR TREATMENT OF MINOR

_____ _____
Student's Name (Please Print) Student's Social Security #

I hereby give consent to treat _____ for routine medical problems, recommended immunizations, and minor emergencies at the UNC Student Health Center. In the event that the above-named student does not meet the immunization requirements to attend college, I hereby give consent for immunizations to be administered as needed to meet the requirement. I understand that contraindications and side effects of the immunization will be reviewed with my minor child and he/she will be asked to sign a further consent at the time immunizations are to be administered. I further understand that costs or fees are my responsibility.

I understand that this authorization is valid until the time in which the minor identified above reaches his/her 18th birthday.

_____ _____
Signature of Parent/Guardian if Student Under 18 Years Date

UNIVERSITY of
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The Student Health Center is intended for only the care of currently enrolled students and their eligible spouses who have paid the health fee.

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

The Health Center is able to 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 the hospital Emergency Room, you are responsible for all those charges. If you have any chronic illness it is also highly suggested that you obtain care from a local provider who would be available to you 24 hours a day.

All students are reminded that medical services are rendered and charged to the patient, not the insurance company. However, as a courtesy to our students who have the Student Health Insurance Program (SHIP), we will file those claims for you.

I hereby authorize the Student Health Center to release to my insurance company any and all information they may require concerning my care. INITIAL: _____

Assignment of benefits; I authorize the payment of any benefit from the SHIP directly to the UNC Student Health Center. INITIAL IF YOU HAVE UNC INSURANCE:_____

Worker's Compensation and Auto Related Injuries:

The Student Health Center does not provide any care related to either of these conditions. You will need to contact your employer or your auto insurance company to see how to proceed.

EVERYONE COMPLETE BELOW:

Signature: _____

Date:_____

PLACE LABEL HERE:

UNIVERSITY of
NORTHERN COLORADO

Assignment of Benefits · Financial Agreement·

Patient Name:_____

I hereby give lifetime authorization for payment of insurance benefits be made directly to UHS, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

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

Your 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 the time of service may result in being registered as a self-pay until copy has been obtained.

I understand that I am responsible for verifying my insurance benefits and 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 is not a guarantee of payment from my insurance company.

Patient Signature: _____

Date: _____