UCF Health
COLLEGE OF MEDICINE PRACTICE

Patient Name: ______________________

Date of Birth: ______________________

HEALTH HISTORY QUESTIONNAIRE

Primary Care Physician: ______________________

Other physicians you currently see: ______________________

Emergency Phone #:______________ Contact Person/Relationship: ______________

Reason for the Visit: ______________________

Please list your medications and respective dosages in the chart below and provide the reason why you take it.
Please list all vitamins, over the counter medications, herbal medicine, etc.

Medication	Dose (units or mg)	Frequency	Reason/Prescribed Date

Preferred Pharmacy
Name:______________________
Address:______________________ Zip Code:______________

Chronic Medical Problem List	Date Diagnosed	Chronic Medical Problem List	Date Diagnosed

Allergies	
Substance or Medication	Reaction

Patient Name: ________________________________ **Date of Birth:** ______________________________

Past Surgical History

Procedures | Surgeries | Hospitalization	Date

Family History

Yes	No	Condition	Family Member(s)
☐	☐	Alzheimer's / Dementia	
☐	☐	Breast Cancer	
☐	☐	Colon Cancer	
☐	☐	Depression	
☐	☐	Diabetes	
☐	☐	Elevated Cholesterol	
☐	☐	Heart Disease/Stroke	
☐	☐	High Blood Pressure	
☐	☐	Ovarian/Prostate Cancer	
☐	☐	Skin Cancer	
☐	☐	Thyroid Disease	
☐	☐	Other	

Preventative Health Screening

Screening	Date
Last Colonoscopy	
Last Mammogram	
Last Pap Smear	
Bone Density/DEXA	

Do you have an Advance Directive? ☐ No
☐ Yes *Date*: ___________

If No, would you like to receive information? ☐ Yes ☐ No

Social History

Alcohol: ☐ Never
☐ Current
☐ Past

For Current or Past use: ☐ Beer ☐ Wine ☐ Hard Liquor

Amount/Day:_____________Number of years:_________

Tobacco (cigarettes, chewing, etc.): ☐ Never
☐ Current ☐ Past - *Year Quit*_____________

For Current or Past use:

Amount/Day:____________Number of years:_________

Employment: ☐ Currently ☐ Disabled ☐ Part time
☐ Retired ☐ Student ☐ Unemployed ☐ Other

Occupation: _____________

Education: ☐ High School ☐ College ☐ ___________

Marital Status: ☐ Single ☐ Married ☐ Life Partner
☐ Separated ☐ Divorced ☐ Widowed

Exercise: ☐ No
☐ Yes Times per week: __________
Duration (average number of minutes):__________

Vaccination History

Vaccine	Date
Influenza (Flu Shot)	
Tetanus (Td/Tdap)	
Shingles (Zostavax)	
Pneumonia	
Hepatitis B series	
Meningitis	
HPV/Gardasil series	
Other	

I certify that my *Health History Questionnaire* is accurate. I further certify that I have read and agree to the *Patient Policies and Procedures & Notice of Privacy Practices* (rev. 122009.01) located at **UCF Health Website (www.ucfhealth.com/privacy)** including:
1) *Payment and Billing Policy & Procedures*;
2) Disclosure of Information for Reimbursement & Assignment of Benefits; 3) *Notice of Privacy Practices (HIPAA)*

______________________________________ ______________________

Patient Signature *(or caregiver/ parent/guardian if minor)* **Date**

If signed by the Patient's Representative, please print name and describe relationship to patient or other authority to act:

______________________________________ ______________________

Name Relationship to Patient

UCF Health

COLLEGE OF MEDICINE PRACTICE

PATIENT REGISTRATION FORM

Today's Date: ______________________ Are you a current UCF COM student? ☐Yes ☐No

Patient's Last Name:______________________First Name:_____________________Middle Name:_____________

Birth Date:______/______/_______ Gender: ☐ Male ☐Female ☐Visually Impaired ☐Hearing Impaired

Address:____City: _______________________

State:_________ZIP Code: ______________

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Partner

Spouse/Partner's Name: ____

Primary Language____________________Race________________________Ethnicity_____________________

Parent / Guardian Name if Patient is a minor:

Last Name:_________________________First Name:_________________________Middle Name:________________

Address if different:_________________________________City:________________State__________Zip ___________

The following information will assist us in communicating with you about your care while protecting your confidentiality. When we return calls and an answering machine picks up, we do not leave a message if the recorded message on the machine does not list the patient name. Information will also not be left with an unauthorized person who may answer the telephone.

Preferred Method(s) of Contact:

Home Phone:___________________Mobile Phone:____________________Work Phone: ______________________

*Email: ____

*Email used for appointment reminders only.

May we speak with someone other than you when confirming your appointment?

☐ Do not leave me a message or release information to anyone. Please speak to me directly.

☐ Yes – Please speak only to the person listed below.

Name:____Relationship to Patient: ________________

<u>UCF Health</u>

<u>Emergency Contact Information</u>

Name:_______________________________Relationship_______________Phone___________

Name:_______________________________Relationship_______________Phone___________

Name:_______________________________Relationship_______________Phone___________

I, ___________________________(patient's name) certify that the above information is my personal information and has not been fraudulently derived. I understand that is it is my responsibility to notify UCF Health of any changes to the above.

____ ____________________

Signature of Patient or Patient's Authorized Representative Date

**If signed by the patient's representative, please print name and describe relationship to patient or other authority to act:

____ _______________________________

Name Relationship to Patient

How Did You Hear About Us?

1. How did you hear about us? Please check **THE PRIMARY** way you heard about us.

_____ Friend or Family	_____Printed Article
_____ Physician Referral	_____Email
_____ Insurance Company	_____Internet
_____ UCF Student Health	_____Social Media
_____ Information by Mail	_____Corporate Event
_____ Television	_____Community Event
_____ Radio	_____Event at UCF Health

_____ Other (Please explain): ____

2. What is your zip code? __________________

3. If you would like to receive periodic health information, please give us your name and email:

Name:____________________________________Email: ______________________________________

UCF Health

COLLEGE OF MEDICINE PRACTICE

CONSENT TO TREATMENT AND FINANCIAL AGREEMENT

Patient's Name: ____

Date of Birth:_______/______/______ Date of Visit:______/______/______

I. **Authorization for Routine Diagnostic Procedure and Treatment** – I hereby consent to such diagnostic procedures and treatments including physiological, psychological and behavioral health services, which in the judgment of my health care provider may be considered necessary or advisable. I recognize that the UCF Health physicians and staff are employees of a health care teaching and research institution and that my treatment and care may be observed and in some instances aided by students and residents under appropriate supervision. I consent to UCF Health taking photographs of me in the course of and related to my treatment and I consent to the use of such photographs and my medical data for educational purposes by UCF Health. I also hereby authorize UCF Health to retain, preserve and use for scientific, educational or research purpose, or dispose of as they might deem fit, any specimens or tissues taken from my body.

II. **Assignment of Benefits and Responsibilities for Payment** – I hereby assign to UCF Health payment from all third party payors with whom I have coverage or from whom benefits are or may become payable to me, for the charges of any health care services I receive for, related to, or connected with this visit or treatment by UCF Health (past, present, or future). I agree to be personally responsible for payment of any health care services that are not covered by third party payors, including, but not limited to, non-covered or out-of-network services, deductibles, co-insurance, and/or co-payments. Third party payors include, but are not limited to, coverage available from: Medicare, Medicaid, Tri-care, or governmental programs; health, accident, automobile, or other insurance; worker's compensation; HMO (commercial, Medicaid, Medicare); self-insured employers; and any sponsors who may contribute payment for services.

III. **Psychology/Psychiatry Services Records** – I hereby understand and agree that my medical record containing psychiatry, psychological and behavioral health information may be available to physicians, nurses, medical assistants, students and other staff at UCF Health, and discussion of my case may occur between a student, a resident, and his/her supervisor alone or in small groups of students or residents for whom the supervisor has responsibility.

IV. **Prescription History** – I understand that performing a medication reconciliation in order to prevent adverse drug interactions and overdose is a critical component to my care. By signing this form, I authorize my provider to query and review my medication fill history including drug, dose, form, strength, prescribing provider, and pharmacy.

V. **Use and sharing of health information**– By signing below as Patient/Representative I hereby authorize UCF Health and its physicians providing services during treatment and care, to release information from and/or copies of my medical records (including information relating to psychiatric and/or psychological care, alcohol and/or substance abuse, genetic diseases and test results, sickle cell anemia, tuberculosis, birth control, abortion, sexually transmitted diseases, and HIV/AIDS tests) and other information as may be required for my treatment and quality assurance, to secure payment for charges incurred by me or on my behalf, to any UCF Health affiliated facility or provider, to other treating providers (including health care providers outside UCF Health), to third party payors for which I have assigned benefits for my treatment and care, to any sponsors that UCF Health may later obtain to contribute payment for my treatment and care, and to any and all regulatory and/or accrediting organizations as necessary for UCF Health to maintain its licensure and accredited status as well as for participation in utilization review and Healthcare Effectiveness Data and

Information Set (HEDIS) reporting to insurance companies. I also authorize release of any information to county, state or federal public health agencies, disease registries, and as required by law.

VI. **Exchange of Health Information** - UCF Health participates in the Commonwell platform, which makes health information available as needed by persons providing medical care, enabling the patient to receive more informed and better coordinated care and to avoid unnecessary duplication of tests, inconvenience and unnecessary cost. By signing below as Patient/Representative, I agree to UCF Health exchanging my health information with other health care providers treating me. This information may include sensitive health information related to mental health conditions and treatment (including psychological and psychiatric care), sexually transmitted diseases, birth control, abortion, substance (drug and alcohol) abuse and treatment, genetic diseases and genetic test results, sickle cell anemia, tuberculosis and HIV/AIDS. I understand I am not required to consent to this exchange of health information as a condition of treatment. I understand that I can opt out of this exchange of health information or revoke my consent effective for future health information by contacting the Health Information Specialist for UCF Health at 407-266-3627 to make that election.

VII. **Workers Compensation** – I hereby authorize UCF Health to release information from and/or copies of my medical records related to the workplace injury or illness, to the employer, workers' compensation insurance carrier, or their attorneys.

VIII. **Guarantor Agreement** – By signing below as Patient/Representative, I hereby agree that all charges connected with the treatment, not covered by any insurance, sponsorship or other third party coverage I may have, are due and payable by me at the time of the visit. If the insurance information I have provided is not active at the time of service or if the services provided are not covered by my insurance plan, I will be responsible for any balance due. The charges I agree to pay are those listed in the current Billing Charge Fee Schedules unless otherwise established by an applicable agreement. I hereby acknowledge that, UCF Health has agreed to bill my insurance or other third party carrier as a courtesy and that UCF Health has the right to demand payment in full from me at any time prior to full payment from any third party payor. If an overdue account is referred for collections, I agree to pay the attorney's fees, court costs and/or collection agency fees associated with the collection process. I specifically waive any exemption of wages from garnishment, which might be available by law, and agree that my wages can be garnished in the event a Judgment is entered against me for collection of the charges for the services provided to me.

IX. **Lien on Third Party Liability Proceeds** – If my treatment is due to an accident or injury, UCF Health shall have a lien upon the proceeds of any cause of action, suit, claim, counterclaim, or demand accruing to me or my legal representative as a result of such accident or injury, in order to recover payment for all charges of health care services I receive for, related to, or connected with such accident or injury (past, present, or future), effective as of the date treatment was first provided. The foregoing shall be sufficient notice to me of the existence of a lien, which shall be effective whether or not it is filed in the public records. The foregoing is in addition to any lien to which UCF Health may be entitled by law.

X. **Agreement to Pay for Professional Component and Other Pathology Services** – Some services such as laboratory and imaging are provided by third party organizations that are not affiliated with UCF Health and I understand I may receive separate bills for these services directly from the organization providing the service, and I agree to be financially responsible for such bills.

By signing below, I acknowledge that I have read this Consent to Treatment and Financial Agreement, that I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction**,** that this form has been fully explained to me and that I understand all of the information in this **Consent to Treatment and Financial Agreement**..

____ ________________

Signature of Patient or Authorized Representative **Date**

If signed by the Patient's Representative, please print name and describe relationship to patient or other authority to act:

_______________________________________ ________________

Name **Relationship or Authority**

Witness Signature____**Date**_____________

Print Name _________________________

_____**My initials here mean that I have received a copy of this form for my record**

COPIES OF THIS STATEMENT SHALL BE AS VALID AS THE ORIGINAL.
ORIGINAL SIGNATURES ON FILE WITH UCF HEALTH.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Name of Patient: ____

Date of Birth: ________________________

I have received a copy of UCF Health's *Notice of Privacy Practices* available at ucfhealth.com/privacy or at the front desk. I understand that UCF Health has the right to change its *Notice of Privacy Practices* from time to time and that I may contact UCF Health at any time to obtain a current copy of the *Notice of Privacy Practices*.

I am Consenting to the disclosure of my protected health information to the following individuals.

Name:___________________________________ Relationship:_________________________

Name:___________________________________ Relationship:_________________________

Name:___________________________________ Relationship:_________________________

_________________________________ _____________________________

Signature of Patient or Patient's Authorized Representative — Date

If signed by the Patient's Representative, please print name and describe relationship to patient or other authority to act:

________________________________ _____________________________

Name — Relationship to Patient

For Office Use Only – To be completed only if no signature is obtained.

I have made a good faith effort to obtain the patient's signature on this form, but was not able to do for the following reason:

❑ Patient (or Patient's Representative) refused to sign.

❑ Other: ____

Signature of UCF Health representative: _________________________________
Date: _______________

Updated 11/21/13