

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

Social History
<b>Alcohol:</b> <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Past  For Current or Past use: <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Hard Liquor  Amount/Day: _____ Number of years: _____
<b>Tobacco (cigarettes, chewing, etc.):</b> <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Past - Year Quit _____  <b>For Current or Past use:</b>  Amount/Day: _____ Number of years: _____
<b>Employment:</b> <input type="checkbox"/> Currently <input type="checkbox"/> Disabled <input type="checkbox"/> Part time <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Other  Occupation: _____  <b>Education:</b> <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> _____
<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Life Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
<b>Exercise:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes    Times per week: _____  Duration (average number of minutes): _____

Family History			
Yes	No	Condition	Family Member(s)
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's / Dementia	
<input type="checkbox"/>	<input type="checkbox"/>	Breast Cancer	
<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	
<input type="checkbox"/>	<input type="checkbox"/>	Depression	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	Elevated Cholesterol	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Stroke	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	
<input type="checkbox"/>	<input type="checkbox"/>	Ovarian/Prostate Cancer	
<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Other	

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

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](http://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

## 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  Non-Binary  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: \_\_\_\_\_

## 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 including 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 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. 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.
- VII. 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.
- VIII. 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.
- IX. 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.
- X. Consent to Telehealth** - Telehealth refers to providing services remotely using telecommunications technologies, such as video conferencing or telephone. This enables the patient and clinician to engage in services while in separate physical locations. There are important differences between in-person sessions and telehealth, and some risks.
- Risks to confidentiality. Because telehealth sessions take place outside of the provider's office, there is potential for other people to overhear or view sessions. UCF Health will take reasonable steps to ensure your privacy, and you are responsible to find a private place for the session where you will not be interrupted and have your desired level of privacy.
  - Issues related to technology. There are many ways that technology issues might impact telehealth. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.
  - Limitations on care. Your UCF Health provider will not be able to conduct a direct physical exam through telehealth which may limit the provider's ability to diagnose and treat some types of conditions.

Video conferencing is an option for conducting remote sessions over the internet where you will be able to speak to and see your provider on a screen. At UCF Health, we primarily use Zoom as a secure video conferencing platform. We will provide you with detailed instructions regarding how to log-in securely. Zoom as used by UCF Health is HIPAA compliant. For more information about Zoom security and privacy, please see: <https://zoom.us/docs/doc/Zoom-hipaa.pdf>. If you are unable to use Zoom, we will work with you to try to arrange an alternative method for telehealth. We strongly suggest that you engage in video conferencing sessions through a computer or device that you know is secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network). Use of videoconferencing and telehealth is completely voluntary. Patients are prohibited from recording these sessions. The UCF Health Notice of Privacy Practices provided to you also applies to telehealth sessions. You understand that UCF Health or you may terminate telehealth services if it is determined to be an inappropriate mode of providing care for you. Any internet-based communication is not 100% guaranteed to be secure/confidential. Technical problems could occur. In a crisis or emergency situation that needs immediate attention, or if you are considering seriously harming myself or someone else, you should dial 911, or go to a hospital/ER.

Your signature below confirms that you have been informed of and understand the risks involved with using the videoconferencing and other telehealth technology, agree to the terms listed above and hereby voluntarily consent to the use of video or other telehealth sessions with a UCF provider with full understanding of the risks listed above, and agree that UCF Health will not be held liable for any of the limitations of telehealth visits described above. This Consent will last for the duration of your relationship with UCF Health unless you withdraw consent for video sessions; in writing at any time, and UCF Health will work with you to find a suitable alternative.

Zoom Meetings and Driver's Safety: UCF Health does not recommend the use of Zoom or participation in a telehealth visit while operating a motor vehicle. Therefore, we reserve the right to end any telehealth patient visit if we have cause to believe that you are participating while operating a vehicle and assess a \$50 fee directly to the patient for loss of Provider time. A new appointment may be scheduled after the fee is collected and the new appointment will be charged through the standard office visit fee schedule accordingly.

**By signing below, I acknowledge that I have read this entire 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** \_\_\_\_\_

**Printed Name** \_\_\_\_\_

\_\_\_\_\_  
**Date**

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



COLLEGE OF MEDICINE PRACTICE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT & EMERGENCY CONTACT INFORMATION

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 and I consent that the below individuals should be listed as my emergency contacts within my patient chart.

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 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: \_\_\_\_\_

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: \_\_\_\_\_