

PATIENT HISTORY

STUDENT HEALTH SERVICES

Minnesota State University, Mankato

Name: _____ (Last) _____ (First) _____ (Middle) SS#: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male Date of Birth: _____ (MONTH) _____ (DAY) _____ (YEAR) Age: _____																																									
Tech ID#: _____ Cell/Telephone: (_____) _____																																									
Local Address: _____ (No. and Street) _____ (City) _____ (State) _____ (Zip)																																									
Permanent Address: _____ (No. and Street) _____ (City) _____ (State) _____ (Zip)																																									
Insurance Coverage	Do you have insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If <u>Yes</u> , check (✓) by the type of coverage below <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Minnesota State Mankato Student Health Plan (Mega Life): <input type="checkbox"/> Medica <input type="checkbox"/> Domestic <input type="checkbox"/> International <input type="checkbox"/> United HealthCare <input type="checkbox"/> MinnesotaCare/UCare/Blue+ <input type="checkbox"/> Health Partners <input type="checkbox"/> Other, Please list type: _____ *NOTE: Give your card to the receptionist to keep a copy on file* Policy Holder Name: _____ Relationship: _____ Policy Holders Date of Birth: ____-____-____ Policy #: _____ Group #: _____																																								
In Case of Emergency	PERSON TO BE NOTIFIED (Name and Relationship) _____ Phone: (_____) _____																																								
Family History	Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No Check (✓) if any immediate family members have/had: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Mom</td> <td><input type="checkbox"/> Dad</td> <td><input type="checkbox"/> Sibling</td> </tr> <tr> <td><input type="checkbox"/> Tuberculosis (TB)</td> <td><input type="checkbox"/> Mom</td> <td><input type="checkbox"/> Dad</td> <td><input type="checkbox"/> Sibling</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Mom</td> <td><input type="checkbox"/> Dad</td> <td><input type="checkbox"/> Sibling</td> </tr> <tr> <td><input type="checkbox"/> Epilepsy or Convulsions</td> <td><input type="checkbox"/> Mom</td> <td><input type="checkbox"/> Dad</td> <td><input type="checkbox"/> Sibling</td> </tr> <tr> <td><input type="checkbox"/> Allergy or Asthma</td> <td><input type="checkbox"/> Mom</td> <td><input type="checkbox"/> Dad</td> <td><input type="checkbox"/> Sibling</td> </tr> <tr> <td><input type="checkbox"/> Nervous or Mental Illness</td> <td><input type="checkbox"/> Mom</td> <td><input type="checkbox"/> Dad</td> <td><input type="checkbox"/> Sibling</td> </tr> <tr> <td><input type="checkbox"/> Migraine Headaches</td> <td><input type="checkbox"/> Mom</td> <td><input type="checkbox"/> Dad</td> <td><input type="checkbox"/> Sibling</td> </tr> <tr> <td><input type="checkbox"/> High Blood Pressure</td> <td><input type="checkbox"/> Mom</td> <td><input type="checkbox"/> Dad</td> <td><input type="checkbox"/> Sibling</td> </tr> <tr> <td><input type="checkbox"/> Heart Disease</td> <td><input type="checkbox"/> Mom</td> <td><input type="checkbox"/> Dad</td> <td><input type="checkbox"/> Sibling</td> </tr> <tr> <td><input type="checkbox"/> Stroke</td> <td><input type="checkbox"/> Mom</td> <td><input type="checkbox"/> Dad</td> <td><input type="checkbox"/> Sibling</td> </tr> </table>	<input type="checkbox"/> Cancer	<input type="checkbox"/> Mom	<input type="checkbox"/> Dad	<input type="checkbox"/> Sibling	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Mom	<input type="checkbox"/> Dad	<input type="checkbox"/> Sibling	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mom	<input type="checkbox"/> Dad	<input type="checkbox"/> Sibling	<input type="checkbox"/> Epilepsy or Convulsions	<input type="checkbox"/> Mom	<input type="checkbox"/> Dad	<input type="checkbox"/> Sibling	<input type="checkbox"/> Allergy or Asthma	<input type="checkbox"/> Mom	<input type="checkbox"/> Dad	<input type="checkbox"/> Sibling	<input type="checkbox"/> Nervous or Mental Illness	<input type="checkbox"/> Mom	<input type="checkbox"/> Dad	<input type="checkbox"/> Sibling	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Mom	<input type="checkbox"/> Dad	<input type="checkbox"/> Sibling	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mom	<input type="checkbox"/> Dad	<input type="checkbox"/> Sibling	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mom	<input type="checkbox"/> Dad	<input type="checkbox"/> Sibling	<input type="checkbox"/> Stroke	<input type="checkbox"/> Mom	<input type="checkbox"/> Dad	<input type="checkbox"/> Sibling
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Personal History	Check (✓) if you have/had: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Alcohol/ Drug Abuse</td> <td><input type="checkbox"/> Eating Disorder</td> <td><input type="checkbox"/> Tobacco Use: <input type="checkbox"/> Cigarettes</td> </tr> <tr> <td><input type="checkbox"/> Pneumonia</td> <td><input type="checkbox"/> Emotional Problems</td> <td><input type="checkbox"/> Smokeless</td> </tr> <tr> <td><input type="checkbox"/> Tuberculosis (TB)</td> <td><input type="checkbox"/> Thyroid Trouble</td> <td><input type="checkbox"/> Hearing Loss</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Hayfever</td> <td><input type="checkbox"/> Voice/Speech impairment</td> </tr> <tr> <td><input type="checkbox"/> Hepatitis</td> <td><input type="checkbox"/> Menstrual</td> <td><input type="checkbox"/> Learning Problems</td> </tr> <tr> <td><input type="checkbox"/> Rheumatic Fever</td> <td><input type="checkbox"/> Heart Disease</td> <td><input type="checkbox"/> Amputation or permanent impairment</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Migraine Headaches</td> <td><input type="checkbox"/> Confined to Wheelchair (long term)</td> </tr> <tr> <td><input type="checkbox"/> Kidney Disease</td> <td><input type="checkbox"/> High Blood Pressure</td> <td><input type="checkbox"/> Other (specify) _____</td> </tr> <tr> <td><input type="checkbox"/> Ulcers</td> <td><input type="checkbox"/> Cancer</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Vision Loss (Do you wear contacts/glasses)</td> <td>_____</td> </tr> </table> Have you had any surgery? Please specify: _____	<input type="checkbox"/> Alcohol/ Drug Abuse	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Tobacco Use: <input type="checkbox"/> Cigarettes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Emotional Problems	<input type="checkbox"/> Smokeless	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Thyroid Trouble	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hayfever	<input type="checkbox"/> Voice/Speech impairment	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Menstrual	<input type="checkbox"/> Learning Problems	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Amputation or permanent impairment	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Confined to Wheelchair (long term)	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Cancer	_____		<input type="checkbox"/> Vision Loss (Do you wear contacts/glasses)	_____										
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Allergies	Are you allergic to Latex ? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you allergic to <u>ANY</u> medication (penicillin, antitoxin, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No If <u>Yes</u> , list _____ What kind of allergic reaction did you have? <input type="checkbox"/> Hives <input type="checkbox"/> Upset Stomach <input type="checkbox"/> Breathing trouble <input type="checkbox"/> Other _____																																								
Rx	Do you regularly take any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If <u>Yes</u> , list: _____																																								

Privacy Practices Accept Decline

(*Take home copy is available upon request)

Patient Signature

Date



Student Health Services

CONSENT AND PAYMENT AUTHORIZATION FORM

I. Consent and Authorization for Release

I consent to the release by Minnesota State University, Mankato Student Health Services of health records and medical and other information about me to the following:

To an insurer, third party payor, third party administrator or other entity providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews, in accordance with Minnesota Law.

II. Payment Authorization

Payment Responsibility

Except as specifically agreed to in writing by Minnesota State University, Mankato Student Health Services with me or as prohibited by Minnesota State University, Mankato Student Health Services contract with a third-party payor or applicable law, I agree that I am responsible to pay Minnesota State University, Mankato Student Health Services for all services furnished to me by Minnesota State University, Mankato Student Health Services, including but not limited to, charges that for any reason are not paid in full by my insurance, government program benefits, or other third-party payors.

Patient's name: _____

Signature: _____ Date: _____

(Patient's Signature; legal guardian if patient is under 18 years of age.)