

# 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 (School) Address: _____ (No. and Street) _____ (City) _____ (State) _____ (Zip) Permanent Address: _____ (No. and Street) _____ (City) _____ (State) _____ (Zip)																																																								
<b>Insurance Coverage</b>	Do you have insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, check (✓) by the type of coverage below <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Minnesota State Mankato (Student Resources): <input type="checkbox"/> Domestic <input type="checkbox"/> International <input type="checkbox"/> Health Partners <input type="checkbox"/> Medica <input type="checkbox"/> Cigna <input type="checkbox"/> MinnesotaCare/UCare/Blue+ <input type="checkbox"/> United HealthCare <input type="checkbox"/> Preferred One <input type="checkbox"/> Other, Please list type: _____ <b>*NOTE: Give your card to the receptionist to keep a copy on file*</b>																																																							
<b>In Case of Emergency</b>	PERSON TO BE NOTIFIED (Name and Relationship) _____ Phone: ( _____ ) _____																																																							
<b>Family History</b>	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> <td>_____</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> <td>_____</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> <td>_____</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> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Allergy</td> <td><input type="checkbox"/> Mom</td> <td><input type="checkbox"/> Dad</td> <td><input type="checkbox"/> Sibling</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Mom</td> <td><input type="checkbox"/> Dad</td> <td><input type="checkbox"/> Sibling</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Nervous/Mental Illness</td> <td><input type="checkbox"/> Mom</td> <td><input type="checkbox"/> Dad</td> <td><input type="checkbox"/> Sibling</td> <td>_____</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> <td>_____</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> <td>_____</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> <td>_____</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> <td>_____</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	<input type="checkbox"/> Mom	<input type="checkbox"/> Dad	<input type="checkbox"/> Sibling	_____	<input type="checkbox"/> Asthma	<input type="checkbox"/> Mom	<input type="checkbox"/> Dad	<input type="checkbox"/> Sibling	_____	<input type="checkbox"/> Nervous/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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<b>Surgical History</b>	Have you had any surgery? Please specify: _____ _____																																																							
<b>Allergies</b>	Are you allergic to Latex? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you allergic to ANY medication (penicillin, antitoxin, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list _____ _____ What kind of allergic reaction did you have? <input type="checkbox"/> Hives <input type="checkbox"/> Upset Stomach <input type="checkbox"/> Breathing trouble Other: _____																																																							
<b>Rx</b>	Do you regularly take any medications? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list _____ _____																																																							



## 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. Electronic Communication

As a part of my treatment, I also consent to allow Minnesota State University, Mankato Student Health Services to provide electronic communication notifications such as appointment reminders, immunizations, and follow-up appointment requests directly to me. This communication will not include details about my personal health records. I have the right to revoke the electronic communication at any time.

I accept       I decline

### III. 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.

**\* Appointments missed without 24-hour notice may be charged a no-show fee.**

PRIVACY PRACTICES:    I accept       I decline      \*Take home copy is available by request

Patient's name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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