



**UNT**<sup>®</sup>

UNIVERSITY  
OF NORTH TEXAS<sup>™</sup>

## Student Health *and* Wellness Center

1155 Union Circle #305160  
Denton, Texas 76203-5017  
(940) 565-2333  
Fax: (940) 369-7042

List Allergies to Medications

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
ID# \_\_\_\_\_

Name \_\_\_\_\_  
Last First MI  
Race \_\_\_\_\_ Gender \_\_\_\_\_ DOB \_\_\_\_\_  
Parents/Legal Guardian/Spouse \_\_\_\_\_ Tele (\_\_\_\_) \_\_\_\_\_  
Address/City \_\_\_\_\_  
Mother's maiden name \_\_\_\_\_ City/State of **Patient's Birth** \_\_\_\_\_  
Personal usage of: Alcohol \_\_\_\_\_ Drug \_\_\_\_\_ Tobacco \_\_\_\_\_  
Contraceptive Used \_\_\_\_\_  
Routine Medication \_\_\_\_\_  
Do you have a chronic condition? \_\_\_\_\_ If so, who is your treating medical provider? \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_  
Do you currently have or ever had any of the following? Current - C; Past - P

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Emotional/Mental Illness      | <input type="checkbox"/> Colitis or Colon problems | <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> Depression/Sadness            | <input type="checkbox"/> Frequent Indigestion      | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Anxiety/Worry                 | <input type="checkbox"/> GERD (Acid Reflux)        | <input type="checkbox"/> Typhoid Fever             |
| <input type="checkbox"/> Eating Disorder               | <input type="checkbox"/> Stomach Ulcer             | <input type="checkbox"/> Malaria                   |
| <input type="checkbox"/> Excessive Alcohol use         | <input type="checkbox"/> Gall Bladder              | <input type="checkbox"/> Arthritis                 |
| <input type="checkbox"/> Illicit Drug use              | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> Chronic Back Problems     |
| <input type="checkbox"/> Recurrent headaches           | <input type="checkbox"/> UTI                       | <input type="checkbox"/> Chronic Skin Disorder     |
| <input type="checkbox"/> Migraine headaches            | <input type="checkbox"/> Kidney Disease            | <input type="checkbox"/> Unusual Childhood Illness |
| <input type="checkbox"/> Convulsions/Seizures/Epilepsy | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Diminished Hearing            | <input type="checkbox"/> Thyroid Disorder          | <b>Family History</b>                              |
| <input type="checkbox"/> Dizziness/Fainting            | <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Blood Disorder/Disease    |
| <input type="checkbox"/> Visual Disorder               | <input type="checkbox"/> Blood Disorder/Disease    | <input type="checkbox"/> Cancer                    |
| <input type="checkbox"/> Congenital Heart Disease      | <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Diabetes                  |
| <input type="checkbox"/> Heart Disease/Murmur          | <input type="checkbox"/> Chicken Pox               | <input type="checkbox"/> Epilepsy/Seizure          |
| <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Infectious Mononucleosis  | <input type="checkbox"/> Heart Disease             |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> STD                       | <input type="checkbox"/> High Blood Pressure       |
| <input type="checkbox"/> Persistent Cough              | <input type="checkbox"/> Measles                   | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Food/Pollen Allergies         | <input type="checkbox"/> Mumps                     | <input type="checkbox"/> Mental Illness            |
| <input type="checkbox"/> Pneumonia                     | <input type="checkbox"/> HIV                       | <input type="checkbox"/> Other _____               |

**Have any of the above affected your ability to function or cope?**  Yes  No  
Have you ever been hospitalized or had surgery in the past?  Yes  No (List) \_\_\_\_\_

**IMMUNIZATIONS HISTORY:**  
DT \_\_\_\_\_ HepB \_\_\_\_\_ MMR \_\_\_\_\_ Polio \_\_\_\_\_ Meningitis \_\_\_\_\_ Tdap \_\_\_\_\_ Varicella \_\_\_\_\_  
Date Date Date Date Date Date Date Date

**I hereby certify the above history is complete and true.**

Signature of Patient / Parent / or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

UNT Provider Reviewed \_\_\_\_\_ Date \_\_\_\_\_

**See Other Side**

## UNT Authorization and Permission to Treat

### Authorization for Treatment (if patient is over 18 years of age)

I do hereby consent, authorize, and request Student Health and Wellness Center personnel, and/or physician and/or mental health representative and/or other medical representative to whom referral is made, to conduct treatment which they may deem advisable in the event I should require medical care while a student at the University of North Texas. I also agree to pay all charges incurred at the time of service.

### Authorization for Treatment (if patient is under 18 years of age)

I do hereby consent, authorize, and request Student Health and Wellness Center personnel, and/or physician and/or mental health representative and/or other medical representative to whom referral is made, to conduct treatment which they may deem advisable in the event my son/daughter should require medical care while a student at the University of North Texas. I also agree to pay all charges incurred at the time of service.

I understand the Student Health and Wellness Center only files insurance claims to the UNT student endorsed insurance policy.

### Patient Long-Term Signature Authorization

The UNT Student Health and Wellness Center is aware that other departments on campus no longer require the use of you social security number. Please be advised that failure to provide your social security number to the Student Health and Wellness Center will significantly hinder the services available to you (including, but not limited to, lab work, x-rays, pharmacy and education). Your social security number will ONLY be used to provide and access medical services.

I am aware the UNT Student Health and Wellness Center follows federal HIPAA guidelines in protecting my information. The Notice of Privacy Practices (NPP) describes my rights as a patient and how the SHWC may use my Protected Health Information (PHI) for treatment, payment, and operation. At any time, I may request a copy of the SHWC NPP from the Medical Records Department.

I hereby authorize the release of any medical information, in order to process my medical insurance claim, to the UNT endorsed student insurance policy. I authorize payment of medical benefits to the UNT Student Health and Wellness Center. I also authorize the Student Health and Wellness Center to release medical information as necessary for continuing treatments. The person giving this authorization may revoke such authorization at any time in writing. Photocopies of the authorization may be used in place of the original.

### Eligibility for Services:

Students who have paid the medical service fee and are enrolled are allowed access to the SHWC.

Students who are no longer enrolled at UNT are no longer eligible to use the services provided at the SHWC. However, there is an opportunity for continuing students to be seen at the SHWC during the summer by paying a fee for the visit.

Students are allowed to have one follow-up visit to provide continuity of care from a previous medical visit during the first semester of non-enrollment by paying an associated fee. Additional follow-up visits will only be scheduled if they are deemed medically necessary by the provider.

Anticipated Date of Graduation: \_\_\_\_\_

### Address Update Information:

It is the responsibility of the students to provide accurate, updated address information at all times to the university. Failure to do so constitutes a breach of the Student Code of Conduct. Any student who changes their address must notify the Registrar's Office immediately or update information at my.unt.edu. (UNT Policy Number: 18.1.4)

By signing this document, I acknowledge that I understand all of the above information as it is written. Also, I hereby certify the above history is complete and true.

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

Witness: \_\_\_\_\_ Date: \_\_\_\_\_