

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
Alcohol: <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: _____
Tobacco (cigarettes, chewing, etc.): <input type="checkbox"/> Never <input type="checkbox"/> Current <input type="checkbox"/> Past - Year Quit _____ For Current or Past use: Amount/Day: _____ Number of years: _____
Employment: <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: _____ Education: <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> _____
Marital Status: <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
Exercise: <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) 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 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: _____

WHO IS FINANCIALLY RESPONSIBLE FOR THE PATIENT (GUARANTOR)

Patient: Yes No **if no, please provide details below.**

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

Birth Date: ____/____/____ Patient's Relationship to Guarantor: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____ Ext: _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name: _____

Insurance ID # _____ Group # _____

Customer Service or Benefits Phone: _____

Is the Patient the primary policy holder: Yes No Is the Guarantor the primary policy holder: Yes No

If both answers are no, please complete the information below regarding the primary policy holder.

Last Name: _____ First Name: _____ Middle Name: _____

Birth Date: ____/____/____ Patient's Relationship to Insured: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____ Ext: _____

SECONDARY INSURANCE INFORMATION

Do you have secondary insurance? Yes No **If yes, please complete below regarding the secondary insurance.**

Secondary Insurance Company Name: _____

Insurance ID #: _____ Group #: _____

Customer Service or Benefits Phone: _____

Is the Patient the primary policy holder: Yes No Is the Guarantor the primary policy holder: Yes No

If both answers are no, please complete the information below regarding the primary policy holder.

Last Name: _____ First Name: _____ Middle Name: _____

Birth Date: ____/____/____ Patient's Relationship to Insured: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I 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

How Did You Hear About Us?

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

- | | |
|--|--|
| <input type="checkbox"/> Friend or Family | <input type="checkbox"/> Printed Article |
| <input type="checkbox"/> Physician Referral | <input type="checkbox"/> Email |
| <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Internet |
| <input type="checkbox"/> UCF Student Health | <input type="checkbox"/> Social Media |
| <input type="checkbox"/> Information by Mail | <input type="checkbox"/> Corporate Event |
| <input type="checkbox"/> Television | <input type="checkbox"/> Community Event |
| <input type="checkbox"/> Radio | <input type="checkbox"/> Event at UCF Health |
| <input type="checkbox"/> 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: _____

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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 Services Records** – I hereby understand and agree that my medical record containing 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. 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.
- V. 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.

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.

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

Witness Printed Name

Date

_____ **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.



IQ Health Portal Participation Agreement

By signing this form you are granting permission to UCF Health to register you as a member of the UCF Health Patient Portal.

Patient's First, Middle (if applicable), and Last Name

Date of Birth (Month, Day, Year)

Email

Last Four Digits of SSN (This will be your temporary password for registration)

Signature

Today's Date

Administrative Use:

MRN: _____

_____ IQ Health Registration Complete _____ Temporary Password Emailed

Completed By: _____ Date: _____

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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: _____