SAINT MARTIN'S UNIVERSITY

Undergraduate New Patient Paperwork

Name (print): _____ Date of Birth: _____

Today's Date: _____

Current Address (include city, state and ZIP code)	
Current Phone Number (include area code)	Home: Office: Cell:
Current Email Address	
Preferred Method of Contact	☐ Email ☐ Phone ☐ Mail
Address on file with your insurance? (include city, state and ZIP code)	
Emergency Contact Name and Relationship	
Emergency Contact Phone Number (include area code)	

GENERAL INFORMATION						
Marital status (check one)	☐ Single	☐ Married	☐ Divorced			
Status (check one)	☐ 1st year	☐ 2nd year	☐ 3rd year	☐ 4th year	☐ Graduate Student	☐ ESL ☐ Faculty ☐ Staff
Are you in the U.S. military?	☐ Yes	☐ No				
Are you a Veteran with medical benefits?	☐ Yes	☐ No				
What is your SMU major?						
Are you an international student?	☐ Yes	☐ No	What is your home country?			
Are you an SMU athlete?	☐ Yes	☐ No	What sport(s)?			
ETHNICITY (mark all that apply)						
☐ American Indian or Alaska Native	☐ Hispanic	☐ Non-Resident Aliens				
☐ Asian	☐ Multi-Ethnic	☐ Undisclosed				
☐ Black or African American	☐ Native Hawaiian or Other Pacific Islander	☐ White				
HEALTH INSURANCE INFORMATION OR PROVIDE YOUR CARD						
Insurance company's name:						
Group Number:	Identification number:					
Relationship to policyholder (self, spouse, parent, child, etc.) :						

Is this insurance through:

☐ SMU Plan ☐ Your Parent(s)

☐ Parent(s) Employer ☐ Your Employer

☐ Military ☐ Other

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1. List all current medications (prescription strength and supplements): _____

_____

_____

2. Please record if you have been hospitalized or had surgeries in the past *(and year occurred)*:

☐ Appendectomy ☐ Orthopedic Surgery ☐ Tonsillectomy ☐ Other: _____

3. Please record any personal or family history of illnesses:

	Self	Family		Self	Family
Diabetes	☐	☐	Kidney or Liver Disease	☐	☐
Heart Disease/Heart Attack	☐	☐	Depression or Anxiety	☐	☐
High Blood Pressure	☐	☐	Lung Condition (i.e. Asthma)	☐	☐
Cancer	☐	☐	Other: _____	☐	☐

Cholesterol screening is advised for persons 20 years of age and older who have diabetes, heart disease, high blood pressure, obesity (BMI >30), who smoke, have a family history of cardiovascular disease in male relatives younger than 50 or female relatives younger than 60.
If this applies to you, would you like your cholesterol checked? ☐ Yes ☐ No

4. Do you have any known allergies? _____ ☐ Yes ☐ No

5. If your B/P is greater than 135/80 you are at increased risk of Diabetes.
If this is your blood pressure would you like to be screened for Diabetes? ☐ Yes ☐ No

6. Have you smoked at least one cigarette in the past 30 days? ☐ Yes ☐ No
If yes to above, are you interested in quitting? ☐ Yes ☐ No

7. Over the past two weeks, have you felt down, depressed or hopeless? ☐ Yes ☐ No
Over the past two weeks, have you felt little interest or pleasure in doing things? ☐ Yes ☐ No

8. During the past two weeks have you had five or more (for men) or four drinks or more (for women) containing alcohol (beer, wine or liquor) in a row, on at least one occasion? ☐ Yes ☐ No
In a typical week, do you drink on 3 or more occasions? ☐ Yes ☐ No

9. The CDC recommends all persons who have been sexually active to be tested for HIV.
Would you like an appointment for STI testing? ☐ Yes ☐ No

10. Women 21 and older are recommended to have PAP smears every 2 – 3 years.
Women 25 and younger are recommended to be tested for Gonorrhea and Chlamydia.
Would you like a Women's Health appointment? ☐ Yes ☐ No

_____ _____

Patient Signature Date

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Optional Health Care Release of Information for Disclosure to Family or Other Individuals

I, _____, authorize Saint Martin's University Student Health Center to disclose the following health care information: (please check box)

☐ All health care information in my medical record, this **DOES NOT** include HIV/STD/Psychiatric/Drug/Alcohol related information.
☐ All health care information in my medical record, this **DOES** include HIV/STD/Psychiatric/Drug/Alcohol related information.
☐ Appointment information.
☐ Test results.
☐ Other (x-rays, bills, etc.) please specify.

_____

Information may be shared with the following individuals:

Name **Relationship**

_____
_____
_____
_____
_____

_____

Patient Signature

_____

Printed Name

**This authorization is valid until Saint Martin's University Student Health Center receives written revocation from the patient.

This form will be retained in your medical record. Requests for changes may be made at any time.