New Patient Registration Form

UNIVERSITY OF THE INCARNATE WORD
SCHOOL of OSTEOPATHIC MEDICINE

Date:_____ **DOB:**_____

Patients Name:_____ **UIW ID#**_____

Address:_____
Street City State Zip

Email:_____ **Sex:** ☐ **Male** ☐ **Female**

Home Phone:_____ **Cell Phone:**_____

☐ **Employee**

☐ **Student**

Marital Status:

☐ Single: ☐ Married: ☐ Divorced: ☐ Widowed:

If Student (Select Type of Student)

☐ High School ☐ Nursing
☐ Undergraduate ☐ Optometry
☐ Graduate ☐ SOM
☐ MBS ☐ Pharmacy

Emergency Contact:

Name: _____

Home Phone:_____

Cell Phone:_____

Relationship: _____

Insurance Information

Responsible Party: ☐ **Check here if you are the responsible party** (skip to insurance info if box checked)

Name: _____ **DOB:** _____

Address: _____
Street City State Zip

Home Phone:_____ **Cell Phone:**_____

Relationship to Responsible Party: _____

Insurance (Primary):

Insurance Company: _____

Insurance Address: _____

Group # _____ **ID #** _____

Insurance (Secondary):

Insurance Company: _____

Insurance Address: _____

Group # _____ **ID #** _____

Medical History

UNIVERSITY OF THE INCARNATE WORD
SCHOOL of OSTEOPATHIC MEDICINE

Patients Name:_____

Date:_____ **UIW ID #**_____

Chronic Conditions: (check all that apply)

- High Blood Pressure ☐ Diabetes ☐
- Asthma ☐ Depression ☐
- Anxiety ☐ Allergies ☐
- Heart Disease ☐ Cancer ☐

Other: _____

_____

Medications: (include dose and how often)

_____

_____

_____

Supplements/Vitamins:

_____

_____

Allergies: (please include reaction and severity)

_____

_____

Surgeries:_____

Nicotine Use: Yes ☐ No ☐ Past ☐ **Quit Date:**_____

If yes, what type– how often? _____

Alcohol Use: Yes ☐ No ☐ Past ☐ **Quit Date:**_____

If yes, what type– how often? _____

Illegal Drug Use? ☐ Yes ☐ No ☐ Past **Quit Date:**_____

If yes, what type– how often? _____

Family Medical History:

	✓ If currently alive	Age at death	Medical Problems
Father	☐		
Mother	☐		
Maternal Grandmother	☐		
Maternal Grandfather	☐		
Paternal Grandmother	☐		
Paternal Grandfather	☐		
Siblings	☐		

* Preferred Pharmacy: *

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

~or~

☐ **CVS , 4600 Broadway**
(default if no other is indicated)

CONSENT FOR TREATMENT

I request and authorize medical care that UIWSOM Health Service provider(s) may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, osteopathic manual medicine, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

□ I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to results of such diagnostic procedure or treatment.

□ I understand that samples of body fluids and/or tissues may be withdrawn from me (the patient) during routine diagnostic procedures. I authorize UIWSOM Health Services to dispose of the bodily fluids.

□ I have been informed and understand that an HIV (human immunodeficiency virus – AIDS) and/or Hepatitis test may be performed on me with this consent if a health professional or first responder sustains an exposure to my blood or other body fluid.

I hereby authorize and instruct my insurance carrier to make payment directly to UIWSOM Health Services for benefits (payments) otherwise payable to me.

I agree to personally pay for any charges that are not covered by or collected from any insurance program, including any deductibles and coinsurance amounts.

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name:_____ **Date:**_____

Signature:_____

UIW Student/PIDM#_____

University of Incarnate Word

UIWSOM Health Services

Notice of Privacy Acknowledgement Form

UNIVERSITY OF THE INCARNATE WORD
SCHOOL of OSTEOPATHIC MEDICINE

This is not a consent.

By signing this document, you are acknowledging you have received a copy of our Notice of Privacy required under HIPAA. The Notice of Privacy outlines your rights in regard to your protected health information (PHI), the possible uses of your PHI, and how we must protect the confidentiality of your PHI.

Summary of the Notice of Privacy:

You can get a copy of the full version by asking staff or going to health services website at:

http://www.uiw.edu/health/index.html

Your Rights:

- Review and get copy of your protected health information (PHI)
- Amend your PHI
- Receive printed or electronic copy of notice of privacy
- Request restrictions on what information we share and how we share your PHI
- Receive accounting of certain disclosure we have made of your PHI

These rights have special restrictions.

It is important that you read the full Notice of Privacy for further information.

We may use your protected health information to:

- Plan for your care
- Submit for payment for your care
- Coordinate care between providers, specialties, and services.
- When we are required by law to do so.

This list is not all inclusive.

It is important that you read the full Notice of Privacy for further information.

I acknowledge that I have been given a copy of the UIWSOM Health Services Notice of Privacy.

Signature: _____

Date: _____ UIW Student/PIDM #: _____