LAKE SUPERIOR
STATE UNIVERSITY
Health CARE Center

Do you have Durable Power of Attorney? Yes No
If "no", would you like information? Yes No

Date _____

Patient Information

PLEASE USE INK

The purpose of this questionnaire is to aid us in providing quality health care. Please complete the questions as accurately as possible (print legibly). ***This questionnaire and your entire clinical record is strictly confidential and will not be released to anyone without your written consent/signature.***

Name: _____ Today's Date: _____
Last First M.I.

Date of Birth: _____-_____-_____ Sex: ❑ M ❑ F Maiden Name: _____
Month Day Year

LSSU Student: ❑ Yes ❑ No _____ Marital Status: Single Married Widowed Divorced

If yes, # of credit hours this semester _____ Student ID#_____ Social Security # _____

Local Address: _____ Permanent Address: _____
Street Street

_____ _____
City State/Prov Zip/Postal Code City State/Prov Zip/Postal Code

Local Phone: _____ Permanent Phone *(include area code)*: _____

Cell Phone *(include area code)*: _____ E-mail: _____

Can confidential messages be left on your telephone answering machine or voice mail? ❑ Yes ❑ No

Employer Name: _____ Employer Phone Number: _____

Employer Address: _____

May we contact you at work regarding test results, appointments, billing questions, etc.? ❑ Yes ❑ No

Emergency Contact Name: _____ Relationship: _____

Address: _____ Phone Number: _____

Family Physician, Nurse Practitioner, Physician Asst. _____ Phone Number: _____

Local Pharmacy: _____

Please list the person/persons with whom we may inform about laboratory results, x-ray results, diagnosis, appointments, prescription drugs, health care information or billing questions.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Consents

1. **Release of Information —** Authorization is hereby granted to the LSSU Health CARE Center to release to all appropriate third party payors, including patient's insurance companies (including insurance companies' reviewer under control), such information as may be deemed necessary in the completion of an admission of a patient. The undersigned understands this authorization may be revoked at any time, but not retroactive to the release of information made in good faith, on the condition that the LSSU Health CARE Center is informed in writing of such revocation.
2. **Assignment —** I hereby assign to LSSU Health CARE Center all medical benefits now due and payable to me under any applicable insurance policies (including governmental reimbursements), and hereby direct any insurance companies or governmental agencies to pay such benefits directly to said establishment and services furnished by said establishment.
3. **Financial Responsibility —** I/we understand that I/we remain financially responsible to the LSSU Health CARE Center for all charges incurred. I/we also understand the charges are due and payable in United States dollars at Sault Ste. Marie, MI. Each patient's case will be reviewed by the LSSU Health CARE Center's Credit and Collection Department. Payment plans will be set up for each patient. Payments will be made even if I/we have a claim against any third party or third party payor.

I hereby authorize the LSSU Health CARE Center to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper medical care. The information on this page is correct to the best of my knowledge.

Signature _____ Date _____

Adult Patient _____ *Parent* _____ *Guardian* _____