John C. Longest Student Health Center **P O Box 6338**
Phone 662-325-2431 Fax 662-325-8888 **Mississippi State, Mississippi 39762**

_____ - ____ - ______
Last Name First Middle Social Security Number

Local Address City State Zip

Permanent Address City State Zip

(_____)______-________ Male Female Single Married Birthdate_______/_____/______
Local Phone Number Month Day Year

In an emergency, please contact:

Last Name First Middle Address

City State Zip (______)______-________ Home Phone Number (______)______-________ Work Phone Number

Relationship: ______________________

CONSENT TO TREAT

I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Patient/Guardian Signature Date

INSURANCE POLICY HOLDER

(Person who owns policy)

Male Female Married Single

Last Name First Middle Initial

Mailing Address City State Zip

(_____)_____-________ Home Phone Number (_____)_____-________ Work Phone Number Date of Birth_______/______/______ Month Day Year __________ - _______ - __________ Social Security Number

Employer/School____ Relationship to patient**:** Self Spouse Parent

INSURANCE INFORMATION

Insurance Company Name

Mailing Address City State Zip

Group Name/Number:__________________________________ Insurance ID#: ____________________________________

Policy Date — from ____________________ to _____________________

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: ____ Date:______________________

AUTHORIZATION TO PAY PHYSICIAN

I understand that charges are due at time service is rendered. However, if doctor approves, I authorize any insurance benefits be paid to physician.

SIGNED: ____ Date:______________________

Health History

Longest Student Health Center
Mississippi State University

____

Last Name First Middle Social Security Number

(CIRCLE AND/OR FILL IN THE APPROPRIATE BLANK)

FAMILY HISTORY

Relationship	Age	Health (Good, Fair, Poor)	Occupation	Age at Death	Cause of Death
Father	________	G F P	______________	__________	_____________
Mother	________	G F P	______________	__________	_____________
Brother	________	G F P	______________	__________	_____________
Sister	________	G F P	______________	__________	_____________
Brother	________	G F P	______________	__________	_____________
Sister	________	G F P	______________	__________	_____________

FAMILY ILLNESS

Disease	Relationship(Grandparent, Parent, Brother, Sister, Other)				
Diabetes Mellitus	G	P	B	S	O
Kidney Disorders	G	P	B	S	O
Heart Disease before age 45	G	P	B	S	O
Asthma	G	P	B	S	O
Cancer	G	P	B	S	O
Other Heritable Disorders	G	P	B	S	O
High Blood Pressure	G	P	B	S	O

SOCIAL HISTORY

Alcohol Usage (circle one) Never 1/year 1/month 1/week 1/day
(One drink equals: 4 oz. wine, 12 oz. beer, or 1 oz. liquor)

Drug Use: (circle one) Yes No

Tobacco

_______ I don't smoke, dip or chew.
I smoke _____ cigarettes/day for ______ years.
_____ pipes/day for ______ years.
_____ cigars/day for ______ years
I dip ______ cans/week for ______ years.
I chew ______ pouches/week for ______ years.
I quit ______ years ago.

Seatbelts

I use seatbelts ______% of the time while riding or driving.

Helmets

I use helmets _______% of the time while skating, cycles, or ATVs.

Exercise

I exercise enough to sweat and breathe hard _____ times/week

REVIEW OF SYSTEMS (check those which apply to you)

Allergies

_____ Penicillin
_____ Aspirins
_____ Sulfa
_____ Codeine
_____ Other ________________

Nervous System

_____ Bulimia or Anorexia
_____ Head Trauma (concussion)
_____ Headaches
_____ Depression

Operative Procedures

_____ Tonsillectomy _____ +/- Adenoidectomy
_____ Appendectomy
_____ Wisdom Teeth Extractions
_____ Hernia Repair
_____ Knee Surgery, Left or Right
_____ Other ______________________________

Infectious Diseases

_____ Chicken Pox
_____ Mononucleosis

Cardiovascular System

_____ High Blood Pressure

Last Pap Smear ________________________

Current Medications: ____