Student Health Center
801 Leroy Place
Socorro, New Mexico 87801
Phone 575-835-5094
Fax 575-835-5097

Intake Registration Form

PERSONAL INFORMATION **(please print clearly)**

Name: ______________________________ DOB ____________ Age________

Sex/Sex assigned at birth_____ Gender_______ Pronouns________ Ethnicity: ____________________

Address: ______________________________ ____________ ______ ________
Mailing City State Zip

______________________________ ____________ ______ ________
Permanent City State Zip

Home Phone: ( ) __________ Work Phone: ( ) ______________ Cell: ( ) __________

Email: ______________________________

EMERGENCY CONTACT

Name: ____________________ Phone: ____________________ Relationship: ______________

Address: ______________________________ ____________ ______ ________
Mailing City State Zip

INSURANCE INFORMATION (or provide copy – necessary for labs, x-rays, referrals)

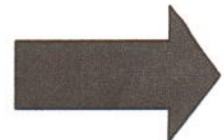
Insurance Company Name: ____

ID#: ______________________________ Group#: ____________________

I hereby authorize New Mexico Institute of Mining and Technology's Student Health Center to release my records to any physician, hospital, medical care facility, or insurance company for healthcare purposes. I also authorize photocopies of this form to be valid as the original. I hereby give my consent to the medical staff of the Student Health Center to examine and treat me and/or my minor child. I also understand that all services I receive are voluntary and confidential. I have also received/read a copy of "Clinic Rights and Responsibilities" and "Clinic Privacy Practices" or I have declined my copy.

______________________________ ______________________________
Signature **Date**

Please fill out reverse side.



PERSONAL HISTORY

Information on this side is for use by the health care professionals at New Mexico Tech's Student Health Center. The contents are confidential and will not be released without your knowledge and consent.

Have you ever had:	YES (current)	YES (previously)	None	Comments/Explanations
Asthma				
Allergies: Medication, Food, Plant, Insect Bites, Other				
Heart Murmur/Problem				
High Blood Pressure				
Kidney Stones/Disease				
Convulsions/Seizures				
Visual Problems				
Hearing Loss				
Arthritis				
Malaria				
Diabetes				
Hypoglycemia/Hyperglycemia				
Thyroid Disease				
Anemia				
Anorexia/Bulimia				
Hepatitis				
Tuberculosis				
Rheumatic Fever				
Bleeding Disorder				
HIV Positive				
Surgery				
Headaches/Migraines				
Emotional Disturbance				
Other				

Do you have a medical disability? Yes No If yes explain: ______________________________

____

Are you currently under a physicians care? Yes No If yes explain: ______________________

____

Please list **any prescriptions and non-prescription medications, supplements** taken (name, dosage, frequency, reason) ____

____

____

Tobacco use / Vape? Yes No Type: ____________________ Frequency/Amount: ____________________
Alcohol? Yes No Type: ____________________ Frequency/Amount: ____________________
Recreational Drugs Yes No Type: ____________________ Frequency/Amount ____________________

Do you have anything you would like to disclose to your care team that would help us provide you with more personalized care? ____

____

____