2023 DHSPC Emergency/Medical Treatment Consent Form

Approved Medical Procedures for

First Name _____ Last Name _____ D.o.B. _____

Emergency/Medical Treatment Consent Agreement

In the event of an emergency or for medical treatment, I hereby give my consent and authorize the University Health Service or the closet Hospital Emergency Department to provide medical services for me. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required, and is to serve as specific consent to any and all such diagnoses, treatment or hospital care, which may be deemed desirable.

Initials _____ Date _____

Emergency Contact Information

Primary Emergency Contact _____ Relationship _____ Phone Number _____

Secondary Emergency Contact _____ Relationship _____ Phone Number _____

Are you currently taking any medication?(If you answer yes, please describe below. If you are not, please indicate N/A)

Do you have any allergies to drugs, medicines, plants, food, etc. (If you answer yes, please describe below. If you do not, please indicate N/A.)

Please list any other previous illness, injury, or surgeries. (If you do not, please indicate N/A.)

Please list any chronic illnesses or physical limitations. (If you do not have any, please indicate N/A.)

Health Insurance Information

Name of Insurance Company _____ Policy Holder's Name _____

I.D. or Contact Number _____ Relationship to Policy Holder _____

Service Code or Insurance Number _____ Policy Holder's Phone Number _____

Group Number or Policy Number _____

Agreement

I request that payment under my medical insurance program be made directly to the sire of services rendered. I understand that I am financially responsible for fees not covered by this authorization.

By entering your initials below you agree to the terms above and ensure that all information is correct.

Initials _____ Date _____