Appendix 21

USA Student Health Center

Patient Information

Patient's Last Name: ______________________________ First: ______________________________ MI: _________

Patient's Social Security Number: __________ -- ________--__________ Jag Number: J00__________________

Patient's Date of Birth (mm/dd/yyyy): _____/_____/_______ Gender(please check) Male: _____ Female: _____Other_____

Patient's Address:
Street: ____ Apt #: _______________________

City: ______________________________ State: __________________________ Zip Code: ________________

Patient's Phone Number:
Home: (____)______ -- ________ Cell: (____) ______ -- ________ Carrier for text messages:________________

Email Address ____________________________________ Referred by: ______________________________________

Insurance Information:
Insurance Co: _______________________________ Policy: _________________________ Grp:________________

Insured's Name Last Name: ______________________ First: ______________________ MI: __________
Insured's Address:
Street: ____ Apt #: _______________________

City: ______________________________ State: __________________________ Zip Code: ________________

Insured's Telephone: (______)__________ -- ___________Insured's Employer: ______________________________

Insured's Date of Birth(mm/dd/yyyy): _____/_____/_______ Relationship to Insured: Child, Self, Spouse, Other (circle)

Consent for Treatment:
I authorize USA Student Health Center and its ag36Td( )Tjpu6Tf2(nt)-5(H)-4(ea)F15p(1th)-58(s)3re T its nt TStude9(h)-6(yy)1re 1(s)3(a)-2

Revised: 11/17/2015