

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

### **Student's Primary Care Provider Information**

At times it is important for the providers to contact the student's primary care providers to discuss their care. Please provide the information below, if available.

Name of Provider: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address \_\_\_\_\_ Fax #: \_\_\_\_\_

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### **Student's Health Insurance Information**

Primary Insurance: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_ Subscriber's relationship to student: \_\_\_\_\_

Insurance ID # \_\_\_\_\_ Insurance Group #: \_\_\_\_\_

**PLEASE ATTACH A COPY OF YOUR INSURANCE AND PRESCRIPTION CARD**

### **Emergency Contact Information**

Student's cell phone#: \_\_\_\_\_ Student's email: \_\_\_\_\_

Emergency Contact #1: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone # \_\_\_\_\_ cell # \_\_\_\_\_ work # \_\_\_\_\_

Emergency Contact #2: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone # \_\_\_\_\_ cell # \_\_\_\_\_ work # \_\_\_\_\_

**If you can not supply the Health Center with your insurance information at the time of your visit, it will be your responsibility to provide the hospital or lab with this information or you will be billed as self-pay.**