



Patient Information

Patient's Last Name:	F11	rst:			MI:	
Patient's Social Security Number:			Jag Numb	er: J00		
Patient's Date of Birth (mm/dd/yyyy):/_	/	_Gender(p	lease check) M	1 ale:	Female:	Other
Patient's Address: Street:			Apt #: _			
City: State	:		Zip C	Code:		
Patient's Phone Number: Home: () Cell: (_)		Carrier for tex	tt message	es:	
Email Address		Referred b	oy:			
Insurance Information: Insurance Co:	Policy: _			Grp	:	
Insured's Name Last Name:Insured's Address: Street:						
City: State	:		Zip C	Code:		
Insured's Telephone: ()		Insured's l	Employer:			
Insured's Date of Birth(mm/dd/yyyy):/_	/	Relations	hip to Insured:	: Child, Se	elf, Spouse, O	ther (circle)
Consent for Treatment: I authorize USA Student Health Center and its as	gents permissi	on to diagn	ose and treat n	ny conditio	on as deemed 1	necessary.
Authorization to Release Information: I authorize USA Student Health Center and its as team and/or my insurance carrier any and all inf claims.						
Assignment of Benefits: I authorize my insurance company or any finance Health. I also understand that should the payme account.						
Financial Obligation: I understand that I may be responsible for any do I understand that any outstanding balance on my University Account. I understand this hold will precords to another university.	account at U	SA Student	Health could r	result in a	"hold" being p	
Signature of Patient or Guardian:				·	_ Date:	

Revised: 11/17/2015