The University of Dallas
STUDENT HEALTH CENTER

PATIENT DEMOGRAPHICS

Patient Name (Last, First, Middle Initial)	Gender	Date of Birth	Univ of Dallas ID#
Home Address	City State Zip		Phone # ◯ cell ◯ home
Email Address			
Emergency Contact Name	Relationship		Phone # ◯ cell ◯ home

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PRIMARY INSURANCE — Outpatient Visit Co-pay Amt:

Insurance Name	Name and Date of Birth of Primary Subscriber
Insurance Address City State Zip Phone #	
Insurance Member ID (or Certificate) #	Group (or Policy) #

Relationship of Patient to Insured: ◯ Dependent ◯ Self ◯ Spouse ◯ Other

Do you have a SECONDARY INSURANCE? ◯ **Yes** ◯ **No** **If so, fill in the following:**

Insurance Name/ Name of Primary Subscriber/ Member ID#/ Group #

Do you have Medicare or Medicaid? ◯ **Yes** ◯ **No** **Medicare/Medicaid No.**

CONSENT FOR TREATMENT, PRIVACY NOTIFICATION AND INSURANCE BILLING

Please check each box and sign below

☐ 1. I understand that the mission of the University of Dallas Student Health Center is to provide preventive medical care; including immunizations and physical exams; to diagnose and treat acute illness and minor emergencies; to help with management of chronic medical conditions; to provide support for mental health concerns; and to provide referrals to specialists as needed. I consent to have the physician on staff treat me for the above conditions.

☐ 2. I acknowledge that I have received and read a copy of the NOTICE OF PRIVACY PRACTICES and understand that my medical information will be kept private except in circumstances as outlined in the notice.

I prefer to be contacted in the following manner (select all that apply): ☐ phone ☐ email ☐ other _____

The following people may have access to my medical information:

Name Relationship to patient ◯ Parent ◯ Spouse ◯ Friend ◯ Other

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☐ 3. I hereby authorize the University of Dallas Student Health Center to furnish information to my insurance carrier(s) concerning my illness, condition and treatment, and I hereby irrevocably assign to The University of Dallas Student Health Center all payments made by my insurance carrier(s) for services rendered. I understand that I will pay all charges, co-pays, deductibles, and coinsurance not covered by my insurance carrier(s) and understand that these charges may be placed on my student account.

☐ 4. The University Student Health Center offers the opportunity for pre-health students to serve as clinic assistants, either as student workers or as interns. I will alert the staff if I prefer *not* to have a student present during my visit.

STUDENT SIGNATURE **DATE**