Name ___________________________________________________ Date of Birth __________________

MEDICAL INSURANCE

Do you have medical insurance?     ____ YES     ____NO  If yes, please attach a copy of your card (both sides)

EMERGENCY NOTIFICATION

Name: _________________________________________   Relationship:  _________________
Telephone Number: _____________________________ Type:   Home, Cell, Work
(Please circle)

HEALTH CARE INFORMATION PREFERENCES

Please check how you would like us to send your confidential health care information. Check all that apply.

☐ You may phone me at: _____________________________________________
   (daytime phone number)

☐ You may leave a phone message:
   ☐ on my voicemail _____________________________
   ☐ with another person at ______________________

If you want us to share any information about you with other person(s), you must list them below, including any and all legal guardians if (a minor) or (unable to consent).

Name ___________________________ Relationship _____________________ Phone # ________________
Name ___________________________ Relationship _____________________ Phone # ________________
Name ___________________________ Relationship _____________________ Phone # ________________

Patient Signature:______________________________________ Date:____________________

Student Health Services
17 High Street, MSC 45
Plymouth, NH 03264
603-535-2350