Georgia State University

Student Health Clinic

141 Piedmont Avenue, Suite D, Atlanta, GA 30303
(P) (404) 413 – 1930

Today's Date: _____ Panther ID #: _____

PATIENT INFORMATION

Patient Name: _____ Birthdate: ___/___/____ Age: ____
Last First MI

Sex: Male Female Marital Status: _____

Home Address: _____

Mailing Address (If Different): _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: _____ Cell: _____ Email: _____

Please Answer All of the Following: Race: _____ Preferred Language: _____

Ethnicity: _____ Religion: _____

CONTACT INFORMATION

Emergency Contact: _____ Relationship to you: _____

Home Phone: _____ Cell: _____ Email: _____

INSURANCE INFORMATION

Insured Name: _____ ID#: _____

Group #: _____ Effective Date: _____ Expiration Date: _____

SIGNATURE OF AUTHORIZATIONS

ASSIGNMENT FOR TREATMENT: Permission is hereby given for medical diagnosis and/or treatment as may be deemed advisable or necessary by the medical staff or **Georgia State University Student Health Clinic. I consent to information about my participation in health services being used for institutional research. I understand that no information containing my name will be released or associated with the research.**

Signature: _____ Date: _____

RELEASE OF MEDICAL INFORMATION: I authorize the release of any medical or other information necessary to help ensure that I receive appropriate services within the Student Health Center and the Counseling and Testing Center.

Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to **Georgia State University**, or the authorized billing service. I also authorize any release of medical information necessary to process claims pertaining to my medical treatment. I understand it is my responsibility to inform this office of any change in my insurance service.

Signature: _____ Date: _____