



**This should be completed directly online in the Patient Portal.  
If you complete the online form, you do NOT need to print, complete, and upload this form.**

Student Contact Information:

College ID # \_\_\_\_\_ Student Cell Phone # **(REQUIRED)** \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
LAST FIRST M.I. MM/DD/YYYY

Home Address \_\_\_\_\_  
STREET CITY, STATE ZIP CODE

Home Phone Number \_\_\_\_\_  
PHONE # (INCLUDING AREA CODE)

Status:  Full Time  Part Time  Undergraduate  Graduate

Age \_\_\_\_\_ Place of Birth \_\_\_\_\_ Race \_\_\_\_\_

Female *While Health Services recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronoun are different from these, please be sure to change it in e-Campus and the patient portal..*  
 Male

Emergency Contact Information:

Specify person to be notified in case of emergency: \_\_\_\_\_  
NAME

\_\_\_\_\_ STREET CITY, STATE ZIP CODE

PHONE # (INCLUDING AREA CODE) CELL PHONE # (INCLUDING AREA CODE)

Name of Primary Care Provider \_\_\_\_\_

Provider's Address \_\_\_\_\_  
STREET CITY, STATE ZIP CODE

Provider's Phone Number \_\_\_\_\_  
PHONE # (INCLUDING AREA CODE)