UCSF Student Health Service - New Student Intake Form

Directions: 1) Please PRINT the following information 2) Mail to Student Health

NAME Last First Middle Social Security # ___ - ___ - ___

Gender: F M Birth date: ___/___/___ UC Clinic Card # (if available) _____

SCHOOL/PROGRAM (circle one)						
Clinical Psych	Dentistry	Dent Hygiene	Dent Post Grad	Dental Res	Dietetic Intern	Graduate Acad
Grad Nurse	Nursing-MEPN	Medicine	Med-MSTP	Pharmacy	Pharmacy Res	Phys Therapy
Special Student (please specify program) _____						

DATE OF ENTRY: ____/____
program begins mo. yr.

Have you been registered at UCSF before? ❒ Yes ❒ No

LOCAL ADDRESS	If Yes, Program _____ Year _____
street address/ apt. #	
city, state, zip code	**EMERGENCY CONTACT**
phone number(s) include area code	Who should be notified in the event of an emergency?
e-mail address (please provide)	relationship to you:
PERMANENT ADDRESS	street address/ apt. #
street address/ apt. #	city, state, zip code
city, state, zip code	Home phone # (include area code)
	Work phone # (include area code)

INSURANCE	**HEALTH CARE PROVIDER**
Do you have health insurance now? ❒ Yes ❒ No	Name of CURRENT Health care provider:
If yes, carrier name:	Address
Policy # Group #	
Termination Date:	phone # include area code
Do you plan to renew coverage after registration? ❒ Yes ❒ No	Last visit (month/year):

Signature of Student _____ **Date** ___/___/___