

University Of New Hampshire Health Services Patient Data Sheet

To avoid delay in registration, please complete and return this form by July 1st for Fall Registration and January 1st for Spring Registration
Please Print All Information

PATIENT REGISTRATION INFORMATION

| | | | | |
|-------------------|---------------|-------|-----|---------|
| PATIENT LAST NAME | FIRST NAME | MI | | |
| STREET ADDRESS | CITY | STATE | ZIP | COUNTRY |
| HOME PHONE | DATE OF BIRTH | SSN# | | |

EMERGENCY CONTACT INFORMATION

| | | | | |
|-------------------|------------|-------------|-----|---------|
| CONTACT LAST NAME | FIRST NAME | MI | | |
| STREET ADDRESS | CITY | STATE | ZIP | COUNTRY |
| HOME PHONE | WORK PHONE | OTHER PHONE | | |

PATIENT INSURANCE INFORMATION

| | | | | |
|--------------------------------|-------------------------|-----------------|-------|--|
| PRIMARY INSURANCE COMPANY NAME | ID/POLICY# | PLAN | GROUP | |
| SUBSCRIBERS NAME | RELATIONSHIP TO PATIENT | INSURANCE PHONE | | |
| INSURANCE MAILING ADDRESS | CITY | STATE | ZIP | |

STUDENT HAS NO INSURANCE COVERAGE

CONSENT STATEMENT AND PARENTAL CONSENT

Should I seek health care at UNH Health Services, I voluntarily consent to treatment by UHN Health Services practitioners.

| | |
|-------------------|------|
| PATIENT SIGNATURE | DATE |
|-------------------|------|

If patient is **under age 18**, parental consent for treatment of a minor is required below:

| | |
|--------------------------|------|
| PARENT/GUADIAN SIGNATURE | DATE |
|--------------------------|------|

PATIENT RIGHTS AND RESPONSIBILITIES

I certify that I have received, read and understand the Patient Rights and Responsibilities document.

| | |
|-------------------|------|
| PATIENT SIGNATURE | DATE |
|-------------------|------|

Please return to:
University of New Hampshire
Medical Records Department
12 Ballard Street
Durham, NH 03824
Phone: 603 862 1530
FAX: 603 862 4259