STUDENT HEALTH CENTER
The University of Texas at El Paso

PATIENT INFORMATION SHEET

Patient Name (Last, first, middle initial)	Gender	Date of Birth	Student ID Number

Address	City/State Zip	Telephone No.

Emergency Contact Name	Relationship	Telephone No.

Is this Work Related? Yes No **If Yes, Date injury occurred**

PRIMARY INSURANCE

Company Name	Name of Insured

Company Address	City/State	Zip

Group No.	Insured's I.D./Certificate No.

Relationship of Patient to Insured Self Spouse Dependant Other

SECONDARY INSURANCE

Company Name	Name of Insured

Company Address	City/State	Zip

Group No.	Insured's I.D/Certificate No.

Relationship of Patient to Insured Self Spouse Dependant Other

ADDITIONAL INSURANCE INFORMATION

Do you have Medicare? Yes No Medicare No.	**Is this an Auto Accident? Yes No**	**Telephone # of Agent**
Do you have Medicaid? Yes No Medicaid No. Effective Thru	**Name & Address of Auto Insurance.**	**Policy No.**

BILLING

As a service to you, our charges will be filed with your insurance company by our billing service.

PLEASE PROVIDE YOUR INSURANCE CARD TO THE PERSON AT THE FRONT DESK.

NEW PATIENT INFORMATION SHEET

I hereby authorize The University of Texas at El Paso's Student Health Center to furnish information to my insurance carrier(s) concerning my illness, condition and treatment, and I hereby irrevocably assign to The University of Texas at El Paso Student Health Center all payments made by my insurance carrier(s) for services rendered. I understand that I will pay all charges, co-pays, deductibles, and coinsurance not covered by my insurance carrier(s) and understand that these charges may be placed on my student account.

SIGNATURE_____ **DATE**_____