UC Health, University Health Services Registration Form

Student: Please fill out all 7 sections of this form in its entirety.

Please be prepared to present your insurance card and photo ID.

1	Name (Last, First, Middle)	
	Birth Date	
	Gender	*Please Circle one:* Male / Female
	Student ID (M) Number	

2	Address	
	Apt./ Unit #	
	Zip code	
	Mobile Phone	Include area code ( )
	Email Address	

3	Please Circle One	Full Time Student / Part Time Student

4	Emergency Contact	
	Home Phone	Include area code ( )
	Work Phone	Include area code ( )
	Mobile Phone	Include area code ( )
	Would you want your emergency contact notified upon admission to the hospital? ***Please Circle one:*** Yes No	

5	How would you like to receive appointment reminders?	*Please Circle one:* Text Calls No Calls
	Ethnicity:	*Please Circle one:* Hispanic Non-Hispanic Declined
	Race:	

6 Health Insurance Information	**The questions below are needed to verify your insurance. Please be sure to answer all questions .**	
	Membership relationship to subscriber: Please check one	☐ I am the subscriber of the health Insurance. ☐ I am the child of the insured. ☐ I am the spouse or significant other of the insured. ☐ Other Please list:
	CARD INFORMATION	
	Name of Insurance Company	
	Group Number	
	Member Number	
	Member Effective from:	
	Group Name	
	Name of subscriber exactly as it appears on the card:	
7 (Purchaser of Health Insurance)	**SUBSCRIBER INFORMATION**	
	Subscriber Name:	
	Subscriber Address	
	Subscriber Zip code	
	Subscriber Birth Date	