University of Alabama in Huntsville
Health Services

INFORMATION FORM

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL

Legal Name _____ **Date of Birth** _____

Chosen Name_____

A # _____ **SSN** (optional)_____ **Marital Status:** _____

Phone: Home _____ **Cell/Mobile**_____ **Mobile Carrier**_____

Local Address _____

Street Address Apt # City State Zip

Occupation:_____**Campus Address** _____

Department Building address

E-Mail Address: _____

Emergency Contact Name: _____**Relationship:** _____**Phone:**_____

Health Insurance Information

Insurance Carrier: _____

Contract Number: _____ **Group Number:** _____

Subscriber/Policy holder's (parent/spouse, etc) Name and Address:_____

_____

Subscriber's DOB_____ **Subscriber's relationship**_____

If Tricare and no card given, we will need Subscriber's SSN_____

Health Care Provider Information

Do you have a health care provider (PCP, MD, NP, etc)? ☐ No ☐ Yes

If you do, please provide the following information. Name: _____

City/State:_____ **Phone Number:** _____

By signing this form, I am requesting health care from UAH Health Services. I am aware that the Clinic's collaborative physician may review my chart when consulting with the nurse practitioner and as part of quality assurance.

Signature _____ **Date** _____