

**University of Alabama in Huntsville
Faculty and Staff Clinic
INFORMATION FORM**

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL

Name _____ Date of Birth _____

A # _____ SSN _____ Gender: Male _____ Female _____

Marital Status: _____

Phone: Home _____ Work _____ Cell _____

Local Address _____
Street Address Apt # City State Zip

Campus Address _____
Department Building address

E-Mail Address: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____ Address: _____

Health Insurance Information

Insurance Carrier: _____

Contract Number: _____ Group Number: _____

Address: _____

Phone Number: _____

Policy Holder Name and Address (Only if different from above): _____

Health Care Provider Information

Do you have a health care provider? No Yes If you do, please provide the following information.

Name: _____

Address: _____

Phone Number: _____

By signing this form, I am requesting health care from the UAH Faculty and Staff Clinic. I acknowledge I am responsible for any laboratory charges. I am also aware that the Faculty and Staff Clinic physician may review my chart when consulting with the nurse practitioner and as part of quality assurance.

Signature _____ Date _____