UF | Student Health Care Center
UNIVERSITY *of* FLORIDA

PATIENT DATA FORM

PATIENT INFORMATION NOTE: In order to be seen at this facility, patients under age 18 must have a parent/guardian sign a Consent and Authorization form.

Name (last, first): _____

Other Names/Aliases, Preferred Pronouns (optional): _____

Date of Birth: _____ **Age:**_____ **Sex:** ☐ **Male** ☐ **Female** Gender Identity (optional):_____
(MM/DD/YYYY)

Last 4 Digits of Social Security Number: _____ **UF ID:**_____ MRN (if known): _____

Ethnicity (check one): ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino**

Race (check all that apply): ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **White** ☐ **Other**
☐ **African American or Black** ☐ **Native Hawaiian or Other Pacific Islander**

Mailing Address: _____

City, State, Zip:_____

Email Address: _____

Home Phone: _____ **Cell Phone:**_____

GUARANTOR INFORMATION NOTE: If patient is financially responsible, write "same as above."

Name (last, first): _____

Mailing Address: _____

City, State, Zip:_____

Home Phone: _____ **Date of Birth:** _____
(MM/DD/YYYY)

INSURANCE INFORMATION

Insurance Company Name:_____ **Policy Number:** _____

Group Number: _____ Has your insurance changed since your last visit? ☐ Yes ☐ No

EMERGENCY INFORMATION

Emergency Contact: _____ **Relationship:** _____

Emergency Home Phone: _____ **Emergency Cell Phone:**_____

TODAY'S VISIT

Reason for Visit:_____

_____

_____

_____

☐ **Check ONLY if you feel your concern needs attention TODAY – a nurse will be with you ASAP.**

I, _____ **, certify that the above information is correct.**

Signature:_____ **Date:** _____

----------DO NOT WRITE BELOW THIS LINE----------

APPT: _____ PROVIDER: _____ DEPT. _____