

Georgia State University
Student Health Clinic
141 Piedmont Ave. Suite D, Atlanta, Ga. 30303 (404) 413-1930

Today' Date: _____ Last 4 digits of SSN# _____

PATIENT INFORMATION

Patient Name: _____ Birthdate: ____/____/____ Age: ____

Last First MI

Student ID _____ Sex: Male Female Marital Status: _____

Home Address: _____

Mailing Address (If Different) _____

City _____ State _____ Zip Code _____ County _____

Home Phone _____ Cell _____ Email _____

Employer Name & Address _____

Spouse Name _____ Phone _____

CONTACT INFORMATION

Emergency Contact _____ Relationship to you _____

Home Phone _____ Cell _____ Email _____

INSURANCE INFORMATION

Insured Name _____ ID# _____

Group # _____ Effective Date _____ Expiration Date _____

SIGNATURE OF AUTHORIZATIONS

ASSIGNMENT FOR TREATMENT Permission is hereby given for medical diagnosis and/or treatment as may be deemed advisable or necessary by the medical staff of **GSU Student Health Clinic**.

Signature: _____ Date: _____

RELEASE OF MEDICAL INFORMATION: I authorize the release of any medical or other information necessary to process claims pertaining to my medical treatment.

Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to **GSU Student Health Clinic**, or our authorized billing service. I understand it is my responsibility to inform this office of any change in my insurance service.

Signature: _____ Date: _____