

COLLEGE HEALTH SERVICES PATIENT CHECK IN SHEET
PLEASE PRINT
FILL OUT ALL INFORMATION

Patient's Name:

Last _____ First _____ Middle _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Birthdate _____ - _____ - _____ Social Security Number _____ - _____ - _____

Allergies(medications) _____

Why did you come to Student Health (health reason): _____

Student _____ Staff/Faculty _____ Visitor _____

Have you been a patient at Student Health before? YES NO

Emergency Contact:

Name _____ Relationship _____

Phone Number _____ Address _____

Alternate Billing Address:

Name (if different than patient) _____

Address _____ City _____ State _____

Zip _____

Please Present Insurance Card to be copied.

Insurance: Student Health will file on the following Insurance (please check correct information)

ReliaStar Student Insurance _____ None/Other _____

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY:

I authorize _____ (name of insurance company) to obtain from Student Health Services any medical information pertaining to myself to process any insurance claim and to release this information to my insurance company. A photocopy of this authorization shall be as valid as original.

Authorization to Pay Benefits: I hereby authorize payment of benefits to College Health Services. I understand that I am financially responsible for any charges not covered by my insurance company.

Financial Policy: It is the policy of College Health Services to require payment at the time of service. Prior arrangements must be made if you are unable to pay for services. Signing below indicates you have read and understand this information. I understand that I am requesting the services of Butler County Community College Health Service and give my permission to be treated.

SIGNATURE OF PATIENT:

Name _____ Date _____

WITNESS:

Name _____ Date _____