University of Alabama in Huntsville
Health Services
Faculty/Staff Clinic
INFORMATION FORM

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL

Name ____**Date of Birth** _______________________

A # _______________________ **SSN** (optional)_____________________ **Marital Status:** ______________

Phone: Home ____________________ **Work** _____________________ **Cell** ________________________

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:** _____________________

Address: ____

Phone Number: ____

Policy Holder Name, DOB, relationship, and Address (Only if different from above):__________________

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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 acknowledge I am responsible for any laboratory charges. Any specimens sent to an outside lab will be billed to my health insurance by that lab and I am responsible for any remaining balance (deductible, copays, etc). I am also 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** _________________________