The University of Dallas
STUDENT HEALTH CENTER

PATIENT DEMOGRAPHICS

Patient Name (Last, First, Middle Initial)	Gender	Date of Birth	Student ID Number
Nottingham, Cameron, J	Male	08/23/1999	900878754

Home Address	City	State	Zip	Phone #
436 Oakwood Ave	Webster Groves	MO	63119	(●) cell ( ) home 314-239-6787

Email Address	
cjnott1999@gmail.com	

Emergency Contact Name	Relationship	Phone #
Brian Nottingham	Father	(●) cell ( ) home 217-971-4909

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PRIMARY INSURANCE — Outpatient Visit Co-pay Amt:

Insurance Name	Name and Date of Birth of Primary Subscriber
Blue Cross Blue Shield	Brian Nottingham November 26 1979

Insurance Address	City	State	Zip	Phone #
PO Box 805107	Chicago	IL	60680	1-800-828-3116

Insurance Member ID (or Certificate) #	Group (or Policy) #
LEG84508439	P75295

Relationship of Patient to Insured: (●) Dependent ( ) Self ( ) Spouse ( ) Other

Do you have a SECONDARY INSURANCE? ( ) **Yes** (●) **No** **If so, fill in the following:**

Insurance Name/ Name of Primary Subscriber/ Member ID#/ Group #

Do you have Medicare or Medicaid? ( ) **Yes** (●) **No** **Medicare/Medicaid No.**

CONSENT FOR TREATMENT, PRIVACY NOTIFICATION AND INSURANCE BILLING

Please check each box and sign below

[■] 1. I understand that the mission of the University of Dallas Student Health Center is to provide preventive medical care; including immunizations and physical exams; to diagnose and treat acute illness and minor emergencies; to help with management of chronic medical conditions; to provide support for mental health concerns; and to provide referrals to specialists as needed. I consent to have the physician on staff treat me for the above conditions.

[■] 2. I acknowledge that I have received and read a copy of the NOTICE OF PRIVACY PRACTICES and understand that my medical information will be kept private except in circumstances as outlined in the notice.

I prefer to be contacted in the following manner (select all that apply): [■] phone [ ] email [ ] other _____

The following people may have access to my medical information:

Name Brian Nottingham Relationship to patient (●) Parent ( ) Spouse ( ) Friend ( ) Other

Name Kate Nottingham Relationship to patient (●) Parent ( ) Spouse ( ) Friend ( ) Other

[■] 3. I hereby authorize the University of Dallas Student Health Center to furnish information to my insurance carrier(s) concerning my illness, condition and treatment, and I hereby irrevocably assign to The University of Dallas Student Health Center all payments made by my insurance carrier(s) for services rendered. I understand that I will pay all charges, co-pays, deductibles, and coinsurance not covered by my insurance carrier(s) and understand that these charges may be placed on my student account.

[■] 4. The University Student Health Center offers the opportunity for pre-health students to serve as clinic assistants, either as student workers or as interns. I will alert the staff if I prefer *not* to have a student present during my visit.

STUDENT SIGNATURE **DATE**