Brooklyn College Health Clinic Intake Form

Name ____

Date of Birth _______/_______/_______ SSN _________/_______/_________

☐ Male ☐ Female // ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other _______________

____
Street Apt No. City State Zip

Phone
day(______)_________________ eve(______)________________ cell: (______)_________________

OK to leave messages? ☐ Yes, no problem ☐ Yes, with caution

Billing address for laboratory testing:

____
Street Apt No. City State Zip

Emergency contact:

____(______)______________
Name relationship address phone

Major ___________________ Expected date of graduation _____________
☐ Full-time ☐ Part-time
UnderGrad: (☐ CLAS ☐ SGS) ☐ Grad ☐ Former student ☐ Faculty ☐ Staff

Medical Insurance? ☐ Yes ☐ No ☐ Don't know If yes, please indicate which type of insurance:

☐ Public (i.e. Affinity Health Plan, Americhoice, Atlantis, CarePlus, Center Care, Community Choice, Fidelis, HealthFirst, HealthPlus, Medicaid, Medicare, MetroPlus, National Health Plan, Neighborhood Health Plan, New York-Presbyterian Community Health Plan, etc.)

☐ Private (i.e. GHI, Aetna, Blue Cross Blue Shield, DC 37, Empire, GHI, Guardian, HIP, Local 1199, Oxford Freedom, US Healthcare, Vista, etc.)

☐Catastrophic (hospitalization) coverage only

CONSENT:
I consent to evaluation and treatment at the BC Health Clinic. I understand that I am responsible for providing accurate health insurance information and/or payment to outside laboratory for any testing provided.

Patient signature: ____ Date: ______________

Minors (Those younger than 18 years old): Please get form at front desk for your parent or guardian's signature.