Powell Student Health Clinic
FIRST VISIT – PATIENT REGISTRATION

Please Print Neatly

Social Security #:			Student ID #:
First Name:	Middle Initial:	Last Name:	
Date of Birth: / /	Gender: *(Circle One)* M F	Marital Status: *(Circle One)* Married Single Divorced	
Address:	Apt #:	Race\Ethnicity:	
City:	State: Zip:	Email Address:	
Home Phone #:		Cell Phone #:	
What are your symptoms and reason for your visit today?			
How long have you had these symptoms?			
Patient Signature:		Is today's visit due to an Injury? Yes No If yes, were you injured at work or on campus? Yes No Which location: Work Campus	

Emergency Contact: *(Please print full name)*

First Name:	Last Name:	Relation:	Phone #: