

**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: <i>(Circle One)</i> M F	Marital Status: <i>(Circle One)</i> 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 #: