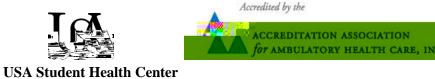
Appendix 21



Patient Information

Patient's Last Name:	First	÷	MI:	
Patient's Social Security Number:	Jag Number: J00_	Jag Number: J00		
Patient's Date of Birth (mm/dd/yyyy):/	_/(Gender(please check) Male:	Female:	Other
Patient's Address:		A #		
Street:		Apt #:		
City: State:		Zip Code:		
Patient's Phone Number: Home: () Cell: () _		Carrier for text messag	ges:	
Email Address	R	Referred by:		
Insurance Information:				
Insurance Co:	_ Policy:	Gr	Grp:	
Insured's Name Last Name:	First: _	MI:		
Insured's Address:				
Street:	A	Apt #:		
City: State:		Zip Code:		
Insured's Telephone: ()	Ir	nsured's Employer:		
Insured's Date of Birth(mm/dd/yyyy):/	_/ F	Relationship to Insured: Child, S	Self, Spouse, O	ther (circle)

Consent for Treatment:
I authorize USA Student Health Center and its ag26Td()Tjjpu6Tf2f(nt)-5(H)-4f(ea)F15p(1nth)-i5f(s)3re T its nt TStuden(h)-f(yy)1re 1f(s)3f(a)-f(yy)1re 1f(s)3f(a)

Revised: 11/17/2015