COLUMBUS STATE UNIVERSITY - STUDENT HEALTH CENTER

PATIENT INFORMATION

Patient Name (Last, first, middle initial)	Preferred Name	Date of Birth	CSU ID# 909

Local Address	City/State	Zip	Cell #

Male: ☐ Female: ☐ ☐	Race	Ethnicity

CSU Email_____@students.columbusstate.edu

Alternate Email_____

Emergency Contact Name and Address	Relationship	Cell #

NOTICES, PERMISSIONS AND ACKNOWLEDGEMENTS

☐ (Initial)

I, _____, hereby authorize the Student Health Center indicated above to furnish all medical records to my insurance carriers concerning my illness, condition and treatment. I understand that I am financially responsible for all charges that may be incurred at the time of visit.

☐ (Initial)

I hereby authorize the Student Health Center, their agents and consultants, to perform diagnostic and treatment procedures, which in their judgment may become necessary while at Columbus State University. If I require specialized and/or emergency care, I will be referred to the appropriate medical facility or professional. I understand that a person listed as my emergency contact will be notified if considered necessary by the professional staff of Columbus State University.

Once you have read and initialed the above and by signing below, you are acknowledging that you have received, read, and understood the Student Health Center's Notice of Privacy Practices (Privacy Notice).
The privacy notice can be found here: https://www.columbusstate.edu/health-services/_docs/CSU-Notice-of-Privacy-Practices.pdf

Student Signature (If 18 or older): _____ Date: _____

INSURANCE INFORMATION

Do you have the Columbus State United HealthCare Student Resource Insurance? Yes ☐ No ☐

If yes, is it International or Domestic? International ☐ Domestic ☐

Reviewed 07/2025