

CLARK ATLANTA UNIVERSITY
STUDENT HEALTH SERVICES
STUDENT INSURANCE/CONTACT INFORMATION SHEET

PLEASE PRINT

Name: _____ 900 Number: _____

Last Four of SSN xxx-xx-____ DOB: __/__/__ Age: ____

Dorm/Local Address: _____ Rm. /Apt#: _____

City: _____ State: _____ Zip code: _____

Phone: (____) _____ - _____

Permanent Home Address: _____ Apt#: _____

City: _____ State: _____ Zip code: _____

Phone: (____) _____ - _____

EMERGENCY CONTACT INFORMATION

Mother:

Father:

Name: _____

Name: _____

Address: _____

Address: _____

City: _____

City: _____

State: _____ Zip: _____

State: _____ Zip: _____

Phone: _____

Phone: _____

Work#: _____ Ext.: _____

Work#: _____ Ext.: _____

Other Phone: _____

Other Phone: _____

INSURANCE INFORMATION

If uninsured, initial here: _____

Policyholder: _____

Employer: _____

Company: _____

Type (HMO/PPO/Other): _____

Group No.: _____

Policy No.: _____

Signature: _____

Date: _____