

UNT Student Health & Wellness Center

Insurance Information			
Patient Information Sheet			
Patient Name (Last, First, Middle)	Sex M F	Date of Birth	Social Security #
Address	City/State	Zip	Telephone No.
Parents Address	City/State	Zip	Telephone No.
Insurance Information Primary			
Insurance Company			Name of Policy Holder
Claim Mailing Address	City/State	Zip	Insurance Phone No.
Policy Holder's I.D./Certificate No.		Group No.	
Relationship of Patient to Policy Holder Other		Self	Spouse Child
Policy Holder's Date of Birth	Policy Holder's Social Security No.	Effective Date of Policy	
Insurance Information Secondary			
Insurance Company			Name of Policy Holder
Claim Mailing Address	City/State	Zip	Insurance Phone No.
Policy Holder's I.D./Certificate No.		Group No.	
Relationship of Patient to Policy Holder Other		Self	Spouse Child
Policy Holder's Date of Birth	Policy Holder's Social Security No.	Effective Date of Policy	

I hereby authorize the UNT Student Health & Wellness Center to furnish information to insurance carriers concerning my illness, condition and treatment, and I hereby irrevocably assign to the SHWC all payments for medical services rendered. I understand that I am financially responsible for all charges that may be charged to my student account.

SIGNATURE: _____ **DATE:** _____