KENT STATE UNIVERSITY | University Health Services

Patient Demographics and Insurance Registration Form

Proof of Insurance is required within two (2) working days from your visit (FAX: 330.672.2272).

Demographics Information

While UHS recognizes diversity of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.

Legal Name: First: ______________________________ Last: ________________________________ Today's Date: _____________

Preferred Name (if different from legal name): ________________________________ Cell Phone #: __________________________

Birthdate (mm/dd/yyyy): _________________ KENT STATE ID #: 8 ___ ___ ___ ___ ___ ___ ___ ___

Sex Assigned at Birth: ☐ Male ☐ Female Personal pronouns (e.g. he/him, she/her): _________________________

Current Gender Identity:

	Male
	Female
	Transgender Male/Trans Man/FTM
	Transgender Female/Trans Woman/MTF
	Gender Queer
	Additional Category (please specify):

Do you think of yourself as:

	Straight or heterosexual
	Lesbian, gay, or homosexual
	Bisexual
	Something else:
	Don't know
	Prefer not to disclose

Country of origin: __________________________________ Language(s) spoken: ____

School/Local Address: ______________________________________ City: ______________________ State: ____ Zip: ___________

Home/Permanent Address: __________________________________ City: ______________________ State: ____ Zip: ___________

Check the address you prefer for mail from Health Services: ☐ School/Local ☐ Home/Permanent

Insurance Information

Are you covered by the *university sponsored* Student Health Insurance Plan? ☐ **Yes** ☐ **No** If yes, SR ID#: __ __ __ __ __ __ __

Are you covered by any other health insurance plan? (Through your parents, your employer, state sponsored plan, marketplace plan, etc.) ☐ **Yes** ☐ **No** *If yes, please **present your insurance card at the desk** and **complete the back of this form**.*

By signing below, I attest that the above information is true and correct to the best of my knowledge.

Insurance Authorization and Assignment:

- I authorize the release of any medical or other information necessary to process this claim.
- I assign directly to University Health Services all medical payments and benefits otherwise payable to me for services rendered.
- I understand that I am financially responsible for any balance not covered or paid by my insurance company.

Patient Signature: ____ Date: ________________

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Print Patient Name: ____ **Birthdate:** ___________________

Please complete the following sections if you have health insurance that is NOT the Student Health Insurance Plan:

Primary Insurance	
Insurance Company Name	
Policy Holder Name	
Policy Holder Birthdate	
Card Information – If you do NOT have a physical copy of your insurance card, please also complete the section below.	
Member/Subscriber ID#	
Group # or Name (optional)	
Effective Date (optional)	
Provider Services Phone #	
Payer ID # (5 digits) (optional)	
Claims submission address (if Payer ID# not available)	

Do you have both primary *and* secondary insurance policies? ☐ Yes ☐ No
If yes, please also fill out the following section:

Secondary Insurance	
Insurance Company Name	
Policy Holder Name	
Policy Holder Birthdate	
Card Information – If you do NOT have a physical copy of your insurance card, please also complete the section below.	
Member/Subscriber ID#	
Group # or Name (optional)	
Effective Date (optional)	
Provider Services Phone #	
Payer ID # (5 digits) (optional)	
Claims submission address (if Payer ID# not available)	

Do you have a prescription insurance card that is separate from your medical insurance card? ☐ **Yes** ☐ **No**
If yes, please present your prescription card at the pharmacy.