

All information you provide on this form is confidential and cannot be released without your permission

Are you Student Staff Faculty Dept. _____ Ext. _____ Visitor Other

(Please Print)	Last	First	Middle	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Home Address:	Number & Street			City & State	Zip Code
Present Mailing Address:	Number & Street			City & State	Zip Code
Phone: Home ()	Work ()		Cell ()		
E-Mail Address:					
Only provide information below that can be used to contact you or another party when the need arises (Emergency Contact) <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other					
Name			Home Phone ()		
Address			Work Phone () Cell Phone ()		
Do you currently have medical insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Type:					
Your Signature		Your CIN		Your SSN	Date

For Student Health Center use only

CHANGE EMERGENCY CONTACT

ADDRESS CHANGE

1. Address _____ Date _____
City _____ Zip Code _____
Phone: Home () _____ Work () _____ Cell () _____
E-Mail Address _____

CHANGE EMERGENCY CONTACT

ADDRESS CHANGE

2. Address _____ Date _____
City _____ Zip Code _____
Phone: Home () _____ Work () _____ Cell () _____
E-Mail Address _____

CHANGE EMERGENCY CONTACT

ADDRESS CHANGE

3. Address _____ Date _____
City _____ Zip Code _____
Phone: Home () _____ Work () _____ Cell () _____
E-Mail Address _____

Common/form/Med-Rec/Patient Address & Notification 7-04



California State University, Los Angeles
STUDENT HEALTH CENTER

PATIENT ADDRESS & NOTIFICATION

Last Name _____
First _____
CIN _____