

**Hamline University Counseling & Health Services
Personal Data Form**

Last Name:	First Name:	MI:	Today's Date:
Hamline Mailstop #:	Date of Birth:	Age:	Home Phone #:
Permanent Address:			Cell Phone #:
			Student ID #:

E-mail Address:

Which phone number is the best number to contact you regarding lab test results?

Insurance/Responsible Party

Primary Insurer

Secondary Insurer

Insurance Company: _____

Policy Holder Name: _____

Policy Holder DOB: _____

Policy Holder S.S. #: _____

Policy or Certificate #: _____

Group #: _____

Insurance Assignment and Authorization

INSURANCE CONSENT: I request that payment of authorized benefits be made to Hamline University Counseling & Health Services on my behalf for any services furnished to me. I authorize the release of my medical information and information needed to determine insurance benefits to any insurance company, third party payer, state medical assistance agency, or other governmental or private payer that I have designated above. I agree to pay Hamline University Counseling & Health Services for any portion of rendered medical services not covered by the designated third party payer(s).

Signature: _____ Date: _____

(TURN OVER)

DEMOGRAPHIC INFORMATION

(For C&HS use only – will not be shared with any third party payers)

University Status: <input type="checkbox"/> First Year <input type="checkbox"/> Sophomore <input type="checkbox"/> Junior <input type="checkbox"/> Senior <input type="checkbox"/> Transfer student <input type="checkbox"/> Graduate Student, 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> year <input type="checkbox"/> Law Student, 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> year <input type="checkbox"/> Other _____		Living with: <input type="checkbox"/> Alone <input type="checkbox"/> Children <input type="checkbox"/> Partner <input type="checkbox"/> Spouse <input type="checkbox"/> Parents <input type="checkbox"/> Roommate(s) <input type="checkbox"/> Other <input type="checkbox"/> On campus <input type="checkbox"/> Off campus	
Major Program: _____ Are you an international student? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, from (country): _____		Enrollment: <input type="checkbox"/> Full-Time GPA _____ <input type="checkbox"/> Part-time <input type="checkbox"/> Not enrolled Are you on academic probation? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Race/Ethnicity (check all that apply): <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian/Asian-American/Pacific Islander <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic/Latino(a) <input type="checkbox"/> Native American <input type="checkbox"/> Other		Sexual Orientation: <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning <input type="checkbox"/> Don't know	
Religious Affiliation/Spiritual Identity (optional): Background: _____ Current: _____		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender - MtF <input type="checkbox"/> FtM <input type="checkbox"/>	
Referred by:			
<input type="checkbox"/> Academic Services <input type="checkbox"/> Career Development Center <input type="checkbox"/> Clergy <input type="checkbox"/> Counselor <input type="checkbox"/> Dean of Students <input type="checkbox"/> Disability Services	<input type="checkbox"/> Faculty <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Health Services <input type="checkbox"/> MISA Office <input type="checkbox"/> Other	<input type="checkbox"/> Physician <input type="checkbox"/> RA or CA <input type="checkbox"/> Residential Life <input type="checkbox"/> Roommate <input type="checkbox"/> Self <input type="checkbox"/> Therapist	Was this a required referral? <input type="checkbox"/> Yes <input type="checkbox"/> No