



Southern California University Of Health Sciences

Welcomes you to the
University Health Center-Whittier

CONFIDENTIAL PATIENT INFORMATION

(Language Assistance Is Available Upon Request)

"How did you hear about us?"

Friends/Family (Is he or she a patient?) Yes No
 Insurance Internet/Website Health Fair Health Seminar Signage Newspaper (Which one?) _____
 Other Healthcare Provider (May we ask who?) _____
 Our Clinicians/Staff/Students (May we ask who?) _____
 Phone Book Verizon AT&T/SBC Chamber Directory Japanese Directory Other _____
 (Please Circle)
Other Resource _____

Name: _____ Home Phone: _____
First Middle Last Cellular Phone: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Email: _____ DOB: _____ Age: _____ Sex: M F

Social Security No: _____ Drivers License No: _____

Marital Status: M S W D Spouse's Name _____ # of Children? _____

Patient's Occupation: _____ Business Phone: _____

Business/Employer Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Family Physician: _____ Phone: _____

I hereby give permission to release information related to my care to my family physician.

In case of an emergency please notify: _____ Phone: _____

IF YOU WERE INVOLVED IN AN ACCIDENT PLEASE COMPLETE THE FOLLOWING:

Did the injury occur at **WORK**? Yes No Date of Injury: _____ Time: _____

Has the injury been reported to your supervisor? Yes No Name of supervisor: _____

Is the injury a result of an **AUTOMOBILE ACCIDENT**? Yes No **OTHER?** _____

I do hereby certify that the preceding questions have been answered truthfully and completely to the best of my knowledge and belief. I understand the University Health Center Whittier, (owned and operated by the Southern California University of Health Sciences), is professionally owned, non-profit institution, and that the clinic is licensed by the Department of Public Health for teaching and research. I understand that I may be examined and treated by students under the supervision of a licensed practitioner, and that the treatment I receive shall be given as outlined by the practitioner in charge of my case.

Patient/Guardian Signature: _____ **Date:** _____