



Southern California University Of Health Sciences

Welcomes you to the
University Health Centers – Whittier& Pasadena

CONFIDENTIAL PATIENT INFORMATION

“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
 (Please Circle) Japanese Directory Other _____
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 _____ #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 Centers, Whittier & Pasadena (owned and operated by the Southern California University of Health Sciences), are professionally owned, non-profit institutions, and that the clinics are 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:** _____