PENNSTATE HERSHEY College of Medicine

PRE-REGISTRATION FORM

Office of Student Health

PLEASE PRINT

Student Name: _____
Last First Middle

Date of Birth: _____ Sex: _____ SSN: _____

Student's Campus Address: _____

Campus Phone Number: or cell _____Marital Status: _____Birthplace: _____

Family Doctor: _____Address: _____

INFORMATION: (policy holder) this information pertains only to students who are medically insured under another person health care plan (e.g. parent, or spouse).

Name: _____Relation to Student: _____

Address: _____

City: _____State:_____Zip:_____

Phone Number: _____ Birth Date: _____

Employer's Name: _____

Employers' Address: _____

INSURANCE INFORMATION: (Please attach copy of both sides of your current insurance card to this form. Also include the date and the student's age at which coverage will end if using parent's insurance.)

BLUE CROSS:

Blue Cross of: _____Subscriber: _____

Subscriber Birth Date: _____Relation to Student: _____

Ins. Group Name: _____Group Number: _____

Identification # or Contract #: _____

COMMERCIAL INSURANCE:

Insurance Name: _____

Address: _____

Insured's Name: _____Relation to Student: _____

Group Name: _____Group Number: _____

Policy Number: _____ Insured's Birth Date: _____

Yes__ No___ I will Purchase the Health Care Insurance Offered by the College Of Medicine.