



Insurance and Health Information (Side One)

Student Name _____

Program & Session: _____

We ask that you fill this form out carefully, accurately, and neatly! This information will be shared only with HMI personnel, consulting and treating medical personnel and other individuals working with HMI. Otherwise, the information will remain confidential.

Our Medical Advisor, Dr. Lisa Zwerdinger, and her partners treat our students when they need medical care. In order to facilitate a possible visit to Rocky Mountain Family Practice or another Emergency Room; please fill in the information below. Please note that all students participating in HMI programs must have health insurance. In addition to providing the following information, please bring any necessary paperwork.

PLEASE PRINT NEATLY, IN INK!

Health Insurance Information

Student's Social Security # _____ Driver's License # & State _____

Person Responsible for Fees _____ Relationship _____

Telephone # _____ Work Telephone # _____ Other Tel # _____

Address _____ City _____ State _____ Zip _____

Insurance Company _____

Claim Address _____

Claim Phone # _____ Subscriber's Name _____

Subscriber's Social Security # _____ Subscriber's Date of Birth _____

Insurance ID # _____ Group # _____

Do you have a prescription or drug card? If so, please include all information we will need to get you a prescription: _____

Dental Insurance Company _____

Dental Ins. Claim Address _____

Dental Insurance Claim Phone # _____

Dental Insurance Subscriber's Name _____

Subscriber's Social Security # _____ Subscriber's Date of Birth _____

Dental Insurance ID # _____

Dental Insurance Group # _____

Please include a photocopy, front and back, of all relevant insurance cards.

If there is any other Insurance Information that would be helpful, please attach additional pages.



Insurance and Health Information (Side Two)

Emergency Contact Information

We will first try to contact your parents. If your parents are not available, who else should we contact if there is an emergency, medical or otherwise? (Please list an adult other than your parents.)

Name: _____ Relationship: _____

Home Telephone #: _____ Work Telephone #: _____

Address: _____

Who should we contact if the person above cannot be reached? (please list an adult other than your parents)

Name: _____ Relationship: _____

Home Telephone #: _____ Work Telephone #: _____

Address: _____

Other Health Information

Are there any physical, mental, or emotional conditions of which your primary care provider or examining physician is unaware? If yes, then please explain in detail. (Please attach additional pages as necessary) _____

Emergency Authorization

The Parent/s authorize HMI staff, representatives or other medical personnel to obtain or provide medical care for the child, to transport the child to a medical facility, and/or to render treatment (including, but not limited to hospitalization, medications, injections, anesthesia or surgery) they consider necessary for the child's health. The Parent/s agree to the release (to or by HMI) of any records necessary for treatment, referral, billing, or insurance purposes. The Parent/s agree that HMI has no responsibility for medical care provided to the child, and agree to pay all costs associated with such care. This form may be photocopied for use in the field.

Student Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

2nd Parent or Guardian Signature: _____ Date: _____

Did you include a photocopy of insurance card (both sides)? Yes No