



California State University Channel Islands
Student Health Services

Patient Registration Form

Date: _____

Name: _____

Date of Birth: _____

Sex: M F

Do you live in on-campus student housing?: Yes ___ No ___ Village and Room #: _____

Local Address: _____

City: _____ Zip Code: _____

Local Phone: _____ Cell Phone: _____

(Please circle your preferred contact telephone number)

Permanent Address: _____

City: _____ Zip Code: _____

Email: _____ Mother's First Name: _____

SS#: _____ Are you a twin? _____

Student ID#: _____

Do you have health insurance? Yes ___ No ___ Family PACT (Green Card)? _____

Please indicate type (HMO/PPO) and name of insurance company: _____

Medical History:

Do you smoke? Yes ___ No ___

Are you allergic to any medications? Yes ___ No ___

Please list:

Please list any chronic medical problems:

Please list any medical problems you have had in the past year:

Please list any medications you are currently taking:

Have you had the Chicken Pox: Infection? _____ Vaccination? _____

For Office Use Only
HAP# _____
EXP: _____