



STUDENT HEALTH AND WELLNESS CENTER

PATIENT DEMOGRAPHIC PROFILE

DATE: _____

Morehouse School of Medicine Clark Atlanta University Morehouse College Graduation Date: _____

Patient Information	
Patient Name: _____	D.O. B. _____
Sex: _____ Race: _____ Ethnicity _____ Preferred Language _____	
Local Address _____	Apt. #: _____
City, State: _____	Zip _____
Permanent Address: _____	Apt. #: _____
City, State: _____	Zip _____
Mobile Phone: _____ Mobile Carrier: _____	Email: _____
Emergency Contact Person _____	R/ship to patient _____ Tel: _____

Guarantor's Name (Person responsible for payment): _____ / R/ship to patient _____

R/ship to patient _____ Guarantor's SSN: _____ Tele3C _____



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PHARMACY INFORMATION:

Local Pharmacy Name _____

Location of Pharmacy: _____ Telephone #: _____

Mail Order Pharmacy (if you use one): _____ Telephone#: _____

ADVANCE DIRECTIVES:

Do you have a donor card? _____ Yes _____ No

Do you have a living will? _____ Yes _____ No (A living will is a written document that allows you as a competent adult to indicate your wishes regarding life prolonging medical treatment if become incapacitated).

Do you have a Durable Power of Attorney for Healthcare? _____ Yes _____ No (A durable Power of Attorney for Healthcare allows you to select an adult to make medical decisions for you).

CONSENT FOR TREATMENT

I grant Morehouse Healthcare permission to provide any medical treatment considered necessary by a clinical provider. I understand that all treatment is voluntary and that I may cease treatment at any time.
