Contact Information

Fall Qtr Date_____ **Winter Qtr Date**_____ **Spring Qtr Date**_____

Legal Name_____
Last First MI

Name Used_____ Pronoun(s)Used_____ Student A#_____

DOB _____/_____/_____ Age_____ Place of Birth_____
Month Day Year

Ethnicity(optional)_____

Local Address _____
Street Apt#

_____
City, State, Zip

WA Resident? ☐ Yes ☐ No
Contact options: Phone ☐ Email ☐ Text ☐ (Cell Provider_____)

Cell Phone_____ Home Phone_____

Email address_____

I understand that the confidentiality of information transmitted via email or text cannot be guaranteed. As a state funded college, email or text via computer is a matter of public record. _____
Initial here

Signature_____

Academic Status (circle) Fresh Soph Jr Senior Grad Program Number of years at TESC____
☐ Yes ☐ No Access Services
☐ Yes ☐ No First Peoples
☐ Yes ☐ No Trio Services
☐ Yes ☐ No Vet Resource Center (Circle Applicable) Active Duty Active Duty Reserve Veteran Dependent or Family of Military Member

We DO NOT BILL or ACCEPT health insurance at Student Wellness Services. All charges go directly to your student account. We ask the information below to facilitate referrals & care coordination, if needed.

Insurance and Primary Care Providers
Do you have medical insurance? ☐ Yes ☐ No Name of medical insurance _____
Do you have a primary care provider (PCP)? ☐ Yes ☐ No (a PCP is the doctor or clinic where you usually or regularly go.)
If yes, contact info_____
Street Suite#

_____
City, State, Zip

_____ _____
Office Phone Office Fax

Do you have a dental provider? ☐ Yes ☐ No Who & When last seen? _____
Do you have a mental health provider ☐ Yes ☐ No Who & When last seen? _____
Do you have a psychiatrist? ☐ Yes ☐ No Who & When last seen? _____

In Case of Emergency, notify:
Name_____ Relationship_____
First Last
Contact info_____
Street Apt#

_____
City, State, Zip

_____ _____
Cell Phone Home Phone