

**IUPUI HEALTH SERVICES  
DEMOGRAPHIC INFORMATION FORM**

**DATE:** \_\_\_\_\_

<b>NAME:</b> _____		
<b>Last</b>	<b>First</b>	<b>MI</b>
<b>ADDRESS:</b> _____		
<b>Street Number and Name</b>		<b>Apt#</b>
_____		
<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>SS#</b> _____	<b>Date of Birth</b> _____	<b>Marital Status S M D W</b>
<b>Home/Cell Phone:</b> _____		<b>Work Phone/Pager:</b> _____
<b>Email</b> _____		

**Employer:** IU       Clarian       Other  \_\_\_\_\_

**Fulltime**     **Part-time**     **Department Name:** \_\_\_\_\_

<b>Student:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
If 'yes' are you:      Fulltime <input type="checkbox"/> Part-time <input type="checkbox"/>
<b>What School are you enrolled (i.e. Medical, Herron, University College...)</b>
_____
<b>School Name</b>
<b>Undergraduate</b> <input type="checkbox"/>
Are you a <b>Freshman</b> <input type="checkbox"/> <b>Sophomore</b> <input type="checkbox"/> <b>Junior</b> <input type="checkbox"/> <b>Senior</b> <input type="checkbox"/> <b>Unknown</b> <input type="checkbox"/>
<b>Graduate</b> <input type="checkbox"/>
Are you also a <b>1<sup>st</sup> year</b> <input type="checkbox"/> <b>2<sup>nd</sup> year</b> <input type="checkbox"/> <b>3<sup>rd</sup> year</b> <input type="checkbox"/> <b>4<sup>th</sup> year</b> <input type="checkbox"/>
<b>Do you have Aneta/Chickering Insurance</b> yes <input type="checkbox"/> no <input type="checkbox"/>

**Emergency Information:**

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_