

# Norton Medical Center/Student Health Services Registration Form

**Student's Name: Last** \_\_\_\_\_ **First** \_\_\_\_\_ **MI** \_\_\_\_\_

For Office Use Only: Wheaton Phone # \_\_\_\_\_ Wheaton Box # \_\_\_\_\_

S.S. # \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

**PLEASE NOTE:** *The information provided here does not constitute a waiver of the Wheaton Student Health Insurance Plan (WSHIP). If your insurance company is U.S. based and provides comparable coverage to Wheaton's plan, you may be able to waive the Wheaton Health Insurance. More information regarding the yearly cost for insurance, how to waive your insurance and when to waive the insurance will be sent to you in an information packet provided to all students in May.*

I plan to be covered by Wheaton insurance.

I have waived Wheaton insurance and will be covered by:

**Primary Insurance:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please attach a copy of your insurance card if you are not purchasing Wheaton insurance.**