

Registration Form
Wheaton College Campus Health Clinic, Norton Medical Center

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: _____

HEALTH INSURANCE INFORMATION

Please Note: *The information you provide here does not constitute a waiver of the Wheaton Student Health Insurance Plan (WSHIP). If your insurance company is based in the U.S. and provides comparable coverage to Wheaton's plan (see enclosed checklist), you may waive the Wheaton Health Insurance. More information regarding the annual cost of the Wheaton Health Insurance plan as well as how and when to waive the Wheaton plan will be sent to you by Student Financial Services at a later date.*

Personal health insurance information:

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 enrolling in the Wheaton Health Insurance plan.

I plan to enroll in the Wheaton Health Insurance plan.