COURI CENTER

for Gynecology and Integrative Women's Health

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Lab Preference: ❒ St. Francis ❒ Methodist ❒ Proctor
Pharmacy Preference: ❒ Lab 1

MRN: _____

(OFFICE USE ONLY)

TODAY'S DATE: _____

PATIENT INFORMATION (PLEASE PRINT)

NAME _____ _____ ____ **DATE OF BIRTH:** _____ / _____ / _____
(Last) (First) (Mi) (Month) (Day) (Year)

SOCIAL SECURITY #: _____ - _____ - _____

ADDRESS: _____

_____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: (____) _____

CELL PHONE: (____) _____

MARITAL STATUS:
❒ Single ❒ Married ❒ Divorced
❒ Separated ❒ Widowed

ETHNIC GROUP:
(FOR MEDICAL STATISTICAL USE ONLY)
❒ White (not of Hispanic origin)
❒ Black (not of Hispanic origin)
❒ Asian of Pacific Islander
❒ American Indian or Alaskan Native
❒ Hispanic
❒ Other

MAY WE CONTACT YOU OR LEAVE MESSAGES ON AN ANSWERING MACHINE AT HOME? ❒Yes ❒No

AT WORK? ❒ Yes ❒ No **FOR APPOINTMENTS?** ❒ Yes ❒ No **TEST RESULTS?** ❒ Yes ❒ No

MAY WE CONTACT YOU BY E-MAIL? ❒ Yes ❒ No **EMAIL ADDRESS:** _____

WHO IS THE PATIENT'S PHYSICIAN? _____
(Primary Care)

EMPLOYMENT INFORMATION

PATIENT EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

WORK PHONE: (____) _____ **EXT:** _____

OCCUPATION: _____

EMPLOYMENT STATUS: ❒ Full-time ❒ Retired ❒ Active Military Duty ❒ Non-Employed ❒ Part-time ❒ Self-Employed ❒ Unknown

GUARANTOR INFORMATION

PATIENT'S RELATIONSHIP TO GUARANTOR: ❒ Self ❒ Child ❒ Spouse Other _____

NAME: _____ _____ ____ **SOCIAL SECURITY #:** _____ - _____ - _____
(Last) (First) (Mi)

ADDRESS: _____

CITY: _____ **STATE:** ____ **ZIP:** _____ **HOME PHONE:** (____) _____

GUARANTOR EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

WORK PHONE: (____) _____ **EXT:** _____

EMPLOYMENT STATUS:
❒ Full-time
❒ Part-time
❒ Retired
❒ Self-Employed
❒ Active Military Duty
❒ Unknown
❒ Non-Employed

(OVER, PLEASE)

EMERGENCY OTHER CONTACT INFORMATION

PATIENT'S SPOUSE NAME: _____ _____ _____
(Last) (First) (Mi)

SPOUSE EMPLOYER:_____ **PHONE: (**___**)** _____ **EXT:** ____

PATIENT'S CAREGIVER (if applicable): _____ _____ _____
(Last) (First) (Mi)

CAREGIVER PHONE: (____**)** _____ **EXT :**_____

EMERGENCY CONTACT NAME (if other than spouse or caregiver):_____ _____ ____
(Last) (First) (Mi)

EMERGENCY CONTACT RELATIONSHIP TO PATIENT: ❒ **Friend** ❒ **Relative** ❒ **Neighbor** ❒ **Caregiver**

DAYTIME EMERGENCY PHONE NUMBER: (_____**)** _____ **EXT:** _____

EVENING EMERGENCY PHONE NUMBER: (_____**)** _____ **EXT:** _____

PATIENT INSURANCE INFORMATION (PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S))

1. PRIMARY INSURANCE NAME: _____

ADDRESS: _____

CITY:_____ **STATE:**____ **ZIP:**_____ **PHONE: (**____**)** _____ **EXT:** ____

POLICY #, MEDICARE#, OR MEDICAID#:_____ **GROUP/CERTIFICATE#:**_____

INSURED NAME (if different): _____

ADDRESS: _____

CITY:_____ **STATE:**____ **ZIP:**_____ **COPAY:** _____

RELATIONSHIP TO INSURED: ❒ **Child** ❒ **Spouse** ❒ **Self** ❒ **Other** _____

DATE OF BIRTH: _____ / _____ / _____
(Month) (Day) (Year)

1. SECONDARY INSURANCE NAME: _____

ADDRESS: _____

CITY:_____ **STATE:**____ **ZIP:**_____ **PHONE: (**____**)** _____ **EXT:** ____

POLICY #, MEDICARE#, OR MEDICAID#:_____ **GROUP/CERTIFICATE#:**_____

INSURED NAME (if different): _____

ADDRESS: _____

CITY:_____ **STATE:**____ **ZIP:**_____ **COPAY:** _____

RELATIONSHIP TO INSURED: ❒ **Child** ❒ **Spouse** ❒ **Self** ❒ **Other** _____

DATE OF BIRTH: _____ / _____ / _____
(Month) (Day) (Year)

Thank You For Choosing

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