COURI CENTER

for Gynecology and Integrative Women's Health

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TODAY'S DATE: ____________

PATIENT INFORMATION (PLEASE PRINT)

NAME ____________ (Last) ____________ (First) ____ (Mi) **DATE OF BIRTH:** ______ (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

MAY WE CONTACT YOU BY E-MAIL? ☐ Yes ☐ No EMAIL ADDRESS: ____________

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

PATIENT INFORMATION (PLEASE PRINT)

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 (PLEASE PRINT)

**For minors, the GUARANTOR is the parent who brings the patient to the appointment.*

PATIENT'S RELATIONSHIP TO GUARANTOR: ☐ Self ☐ Child ☐ Spouse **Other** ____________

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

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 CONTACT INFORMATION

EMERGENCY CONTACT NAME: ______________________ (Last) ______________________ (First) ____ (Mi)

EMERGENCY CONTACT RELATIONSHIP TO PATIENT:

❐ Spouse ❐ Friend ❐ Relative ❐ Neighbor ❐ Caregiver

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

INSURED NAME (if different):____

ADDRESS:____

CITY:__________________ **STATE:**_____ **ZIP:**__________ **COPAY:**__________________

RELATIONSHIP TO INSURED: ❐ Child ❐ Spouse ❐ Self ❐ Other ____________________

2. SECONDARY INSURANCE NAME:____

ADDRESS:____

CITY:__________________ **STATE:**_____ **ZIP:**________ **PHONE:** (____)______________ **EXT:**____

POLICY #, MEDICARE #, OR MEDICAID #:__________________ **GROUP/CERTIFICATE #:**__________

INSURED DATE OF BIRTH:__________/__________/__________
(Month) (Day) (Year)

INSURED NAME (if different):____

ADDRESS:____

CITY:__________________ **STATE:**_____ **ZIP:**__________ **COPAY:**__________________

RELATIONSHIP TO INSURED: ❐ Child ❐ Spouse ❐ Self ❐ Other ____________________

Thank You For Choosing

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