COURI CENTER
for Gynecology and Integrative Women's Health

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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

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 ______________ ______________ ____ **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 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)

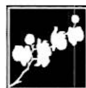
INSURED NAME (if different):____

ADDRESS:____

CITY:__________________STATE:____ZIP:________COPAY:______________________

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

Thank You For Choosing



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