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: (_____)____________

EMAIL ADDRESS: ____________________

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

GENDER IDENTITY: ❒ **Female** ❒ **Male** ❒ **Transgender Male** ❒ **Transgender Female** ❒ **Other** ______

PRONOUNS: ❒ **she/her/hers** ❒ **he/him/his** ❒ **they/them/theirs** ❒ **Other** ________

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

COURI CENTER
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