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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