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: (_____ **)** _____

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

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: ❒ **Employed** ❒ **Retired** ❒ **Active Military Duty** ❒ **Non-Employed**
❒ **Homemaker** ❒ **Self-Employed** ❒ **Student**

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: _____

BILLING ADDRESS: _____

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

POLICY #, MEDICARE # (Required):_____**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: _____

BILLING 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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