Patient Information Form

CMU HEALTH
CENTRAL MICHIGAN UNIVERSITY

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable):
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	
Preferred Contact Method: ☐ Home ☐Cell ☐Work ☐ MyChart ☐ Email	Driver's License # (If child, please use parent's #)	Date of Birth:	
Family Physician or Pediatrician:		Sex: ❑ Male ❑ Female	
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #: ( )	Email Address:	Relationship to Patient:	

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:		First Name:	
Date of Birth:	Social Security #:	Sex: ❑ Male ❑ Female	Phone: ( )
Address of Person Responsible:			
City/State/Zip:		Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

How did you hear about us?	**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Prefer not to say	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to say

Employer:	**Employer Address:**	**City/State/Zip:**	**Employer Phone:** ( )

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I hereby authorize CMU Health to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature of Responsible Party: X _____ **Date:** _____

Printed Name of Responsible Party: X _____

Witness Signature: X _____ **Date:** _____