CUMMINS
women's health + wellness

## PATIENT

Patient Name: _____ Date of Birth: _____

Street Address: _____ SSN: _____

City / State / Zip: _____ Marital Status: S ◯ M ◯ D ◯ W ◯

Employed: Y ◯ N ◯ Mobile Phone: _____

Employer: _____ Home Phone: _____

Pharmacy: _____ Email: _____

Pharmacy Phone Number: _____ Emergency Contact: _____

Family Physician: _____ Phone Number: _____

How did you hear about us? _____

## SPOUSE OR PARENT/GUARDIAN

Name: _____ Date of Birth: _____

Street Address: _____ Mobile Phone: _____

City / State / Zip: _____ Relation to Patient: _____

Employer: _____

## INSURANCE INFORMATION

Insurance Provider: _____ ID Number: _____

Insured's Name: _____ Group Number: _____

Insured's DOB: _____

**Please bring your insurance card with you to each appointment.**

I authorize the release of any medical information required to determine benefits or facilitate insurance reimbursement. I understand I am financially responsible for all charges whether or not they are covered by insurance. I also understand I may have a copy of our Notice of Privacy Practices at any time upon my request.

Patient Signature (or responsible party if patient is a minor)

_____ Date: _____