

Patient Demographics Form

PATIENT/STUDENT INFORMATION

Name: _____ SS#: _____ DOB: _____
Last First MI

Sex (Circle one) : Male/Female Race: _____ Religion: _____

Home Address: _____
City/State Zip

Home Phone: _____ Cell Phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Student: _____
Last First MI

Home Address: _____
City/State Zip

Home Phone: _____ Cell Phone: _____

INSURANCE PLAN INFORMATION (we must have the policyholder's address and DOB in order to bill your plan)

Insurance Company: _____ Phone Number: _____

Address: _____
City/State Zip

Policy/Certificate #: _____ Group #: _____ Copay: _____

Policyholder's relationship to student: Parent Guardian Self

Policyholder's Employer: _____ Employer Phone: _____

Employer Address: _____
City/State Zip

Policyholder: _____ SS#: _____ DOB: _____
Last First MI

Home Address: _____
City/State Zip

Home Phone: _____ Cell Phone: _____

PRIMARY CARE PROVIDER/DOCTOR INFORMATION

Name: _____ Phone Number: _____

Address: _____
City/State Zip

REFERRAL SCREENING – PLEASE CONTACT YOUR INSURANCE AND ASK THE FOLLOWING QUESTIONS

If you live outside of Maine, does your insurance plan have out-of-state coverage YES NO (*)

Does your insurance plan have out of network coverage YES NO (*)

Does your insurance plan require a referral to be seen at Cutler Health Center (Tax ID # 01-0211501) YES NO

*** If you answered NO to numbers 1&2, please be aware that you may be responsible for all charges incurred during your visit. You may want to consider purchasing the University's student health insurance plan.**

Please include a copy of the front and back of your insurance card. This form can be mailed or faxed to us.

For Office Use Only: Entered On: _____ Initials: _____