PLEASE PRINT CLEARLY

Sindecuse Health Center
WESTERN MICHIGAN UNIVERSITY

(269) 387-3287
(269) 387-3204 fax

Patient Information

Patient

FULL LEGAL NAME (REQUIRED FOR HEALTH RECORDS)

WMU IDENTIFICATION NUMBER (WIN) IF KNOWN

DATE OF BIRTH (MM/DD/YY)

PREFERRED FIRST NAME AT WMU

SEX:
- ☐ FEMALE
- ☐ MALE

GENDER IDENTITY:
- ☐ FEMALE
- ☐ MALE
- ☐ TRANSFEMALE / MTF
- ☐ TRANSMALE / FTM
- ☐ TRANSGENDER
- ☐ GENDER NONCONFORMING
- ☐ DIFFERENT IDENTITY

LOCAL OR WMU ADDRESS

CITY STATE ZIP

PHONE

Primary Insurance

☐ **USE AS PATIENT'S EMERGENCY CONTACT**

POLICY HOLDER 1

NAME

RELATIONSHIP TO PATIENT

DATE OF BIRTH (MM/DD/YY)

PHONE

ADDRESS

EMPLOYER

CITY STATE ZIP

SEX: ☐ FEMALE ☐ MALE

INSURANCE 1

INSURANCE COMPANY

INSURANCE PHONE

CLAIM SUBMISSION ADDRESS

STATE ZIP

CONTRACT/POLICY NUMBER

GROUP NUMBER

Secondary Insurance or Emergency Contact

☐ **USE AS PATIENT'S EMERGENCY CONTACT**

POLICY HOLDER 2

NAME

RELATIONSHIP TO PATIENT

DATE OF BIRTH (MM/DD/YY)

PHONE

ADDRESS

EMPLOYER

CITY STATE ZIP

SEX: ☐ FEMALE ☐ MALE

INSURANCE 2

INSURANCE COMPANY

INSURANCE PHONE

CLAIM SUBMISSION ADDRESS

STATE ZIP

CONTRACT/POLICY NUMBER

GROUP NUMBER

How to submit

Please make a copy of your insurance card front and back, and write the student's name, date of birth, and WIN (if known) next to the card.

Mail this form and a copy of the insurance card(s) to: Sindecuse Health Center, WMU, 1903 W Michigan Ave, Kalamazoo, MI 49008-5445 **or fax** to (269) 387-4494.

Questions?

Call (269) 387-4219 or email shc-insurance@wmich.edu.