PLEASE PRINT CLEARLY

Sindecuse Health Center
WESTERN MICHIGAN UNIVERSITY

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

Patient Information

This form must be completed for Sindecuse Health Center to bill your insurance company.

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

LOCAL OR WMU ADDRESS

CITY

STATE ZIP

PHONE

SEX:
- ☐ FEMALE
- ☐ MALE

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

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

Patient Signature

I authorize Sindecuse Health Center to furnish information to my insurance carrier concerning my illness and treatments. **MEDICARE RECIPIENT AUTHORIZATION:** I request that payment of authorized Medicare benefits be made on my behalf for services furnished me by Sindecuse Health Center. I authorize Sindecuse Health Center to release to the Center for Medicare and Medicaid Services or its agents any information needed to determine these benefits or the benefits payable or related services.

X **PATIENT** OR GUARDIAN SIGNATURE

DATE

Mail this form to: Sindecuse Health Center, Western Michigan University, 1903 W Michigan Ave, Kalamazoo, MI 49008-5445
or fax to (269) 387-4494.

form 109 revised 4/18

Sindecuse Health Center
WESTERN MICHIGAN UNIVERSITY

Tuberculosis (TB) Screening Worksheet for International Students

1. Have you ever had close contact with persons known or suspected to have active TB disease?

2. Were you born in one of the countries or territories listed below that have a high incidence of active TB disease?

Afghanistan
Albania
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bahamas
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong, SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini (formerly Swaziland)
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niue
Niger
Nigeria
North Korea
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Korea (Republic of Korea)
South Sudan
Sri Lanka
Sudan
Suriname
Syrian Arab Republic
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tokelau
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Tuberculosis Report 2018. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

3. Have you had frequent or prolonged visits to one or more of the countries or territories listed above with a high prevalence of TB disease?

4. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities long-term care facilities, and homeless shelters)?

5. Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?

6. Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?

If you were born in one of the countries or territories above, WMU requires you to have TB testing here on campus. You will be able to schedule an appointment when you arrive at orientation.

If the answer is YES to any of the above questions and you are not from one of the countries above, you may have been exposed to TB and will want to consider getting a QFG lab test upon arrival to campus.

Sindecuse Health Center offers testing and treatment for TB exposure.
More information is available at wmich.edu/healthcenter/clinic/services/tb.
To schedule an appointment visit healthmanager.wmich.edu/ or see our representative at orientation.

Sindecuse
Health Center
WESTERN MICHIGAN UNIVERSITY

(269) 387 3287
(269) 387 3204 fax

Medical and Mental Health Treatment Authorization

For patients under the age of eighteen (18) to be seen by clinical and counseling employees at Sindecuse Health Center, this form must be signed. Health Center staff make every effort to contact you in the event of an emergency or serious illness.

I hereby authorize staff of Sindecuse Health Center at Western Michigan University to administer treatment to my son or daughter. This authorization is effective from the date of signature until the patient is of legal age or ineligible to use the facility's services.

I hereby authorize staff of Sindecuse Health Center at Western Michigan University to administer medical treatment to my son or daughter. This authorization is effective from the date of signature until the patient is of legal age or ineligible to use the facility's services.

MINOR'S NAME (PRINT)

WIN (WMU IDENTIFICATION NUMBER)

X

PARENT OR GUARDIAN'S SIGNATURE

DATE

PARENT OR GUARDIAN'S NAME (PRINT)

HOME PHONE #

MOBILE PHONE #

WORK PHONE #