



PARTNER INFORMATION FORM



INFORMATION ON PARTNER

NAME _____ DATE OF BIRTH _____
 LAST FIRST MI MO DAY YR

ADDRESS _____ HOW LONG AT CURRENT ADDRESS _____
 STREET CITY STATE ZIP

SOCIAL SECURITY # _____ PHONE # _____ WORK PHONE # _____

CELL PHONE # _____ Other phone _____ DRIVER'S LICENSE # _____ STATE _____

BIRTH PLACE _____ MAIDEN NAME _____ MARITAL STATUS _____

OCCUPATION _____ EMPLOYER _____ FULL TIME /PART TIME _____

EMPLOYER ADDRESS _____
 STREET CITY STATE ZIP

RELIGIOUS PREF _____ DO YOU HAVE ANY ALLERGIES? _____

DO YOU HAVE AN ADVANCE DIRECTIVE FOR HEALTHCARE/LIVING WILL YES NO (IF YES, ENCLOSE COPY OF DOCUMENT)

INFORMATION ON PATIENT

FULL NAME _____ BIRTH DATE _____
 LAST FIRST MI MO DAY YR

ADDRESS _____ PHONE# _____ CELL# _____
 STREET CITY STATE ZIP

OTHER CONTACT

EMERGENCY CONTACT _____ RELATIONSHIP _____

ADDRESS _____ HM # _____ WK # _____
 STREET CITY STATE ZIP

INSURANCE INFORMATION

FULL NAME OF PRIMARY INSURANCE _____	FULL NAME OF SECONDARY INSURANCE _____
INSURANCE PHONE # _____	INSURANCE PHONE # _____
ADDRESS _____	ADDRESS _____
POLICY # _____ GROUP # _____	POLICY # _____ GROUP # _____
MEMBER # _____ EFF DATE _____	MEMBER # _____ EFF DATE _____
NAME of POLICY HOLDER _____	NAME of POLICY HOLDER _____

AUTHORIZATION:

I understand that I am financially responsible for all charges, including initial consultation whether or not covered by my insurance company. Payment is due at time service is rendered unless insurance is being billed.

ASSIGNMENT:

I permit payment directly to Fertility Specialists Medical Group, Inc. for any benefits due for services rendered.

MEDICAL RECORDS:

1. Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original.
2. Authorization is hereby granted for release of pertinent information to a hospital or to the referring physician for appropriate continuum of care/treatment as required. Regardless of any claim pending, you will receive periodic statements if your account has an outstanding balance. We cannot accept responsibility for collection your insurance claim or for negotiating a settlement on a disputed claim.

SIGNATURE: _____ DATE: _____

E-MAIL ADDRESS _____ Can this email be used for transmittal of health information? Yes No

PARTNER INFORMATION FORM

(Continued)

AUTHORIZATION TO RELEASE MEDICAL RECORDS

This authorization to receive medical information is in accordance to the Confidentiality of Medical Information Act of 1981, Section 56 et seq, of the California Civil Code.

I herby authorize: Fertility Specialists Medical Group, Inc.
8010 Frost Street, Plaza Level
San Diego, CA 92123

To release summary letters and/or my medical records *including*:

All my medical records such as Laboratory results, Ultrasound reports, Office Visits
Please **exclude** the following _____

Urologist Last Name _____ First Name _____
Street _____
City _____ State _____ Zip _____ Telephone (____) _____

Primary Care Last Name _____ First Name _____
Street _____
City _____ State _____ Zip _____ Telephone (____) _____

Partner Name _____ Signature _____ Date _____
SS# _____ DOB _____

DISCLOSURE TO ONE ANOTHER:

By signing below I certify that all information related to me and my partner's care can be shared between us by the staff at Fertility Specialists Medical Group, Inc.

Partner _____