



INFORMATION ON PATIENT

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 PARTNER

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

NOTE: PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.

# PATIENT 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 \_\_\_\_\_

**OB/GYN** Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

**Urologist** Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

**Primary Care** Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Patient 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.

Patient \_\_\_\_\_