……… ……………………: 9A5 @9 ˙D5 H=9BH˙=B: CFA5 H=CB˙: CFA

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____
INSURANCE PHONE #____
ADDRESS____
____
POLICY #_________________________GROUP #_________________
MEMBER #_________________________EFF DATE_______________
NAME of POLICY HOLDER____________________________________

FULL NAME OF
SECONDARY INSURANCE_____________________________________
INSURANCE PHONE #_______________________________________
ADDRESS____
____
POLICY #_________________________ GROUP #_________________
MEMBER #_________________________EFF DATE_______________
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 herby 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.

FEMALE PATIENT INFORMATION FORM

(Continued)

Name ______________________ Signature ______________________ Date ______________________

______________________ ______________________ ______________________

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 ____