



REPRODUCTIVE MEDICINE

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

May we contact you at your home #: \_\_\_\_\_ or cell phone #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Employer: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Phone: \_\_\_\_\_ may we contact you at this number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

How did you hear of our practice? \_\_\_\_\_

Number of children Living: \_\_\_\_\_ Number of miscarriages: \_\_\_\_\_ Pregnancies: \_\_\_\_\_

Parent or Spouse: \_\_\_\_\_ SS#: \_\_\_\_\_ (circle one)

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Employer: \_\_\_\_\_

Phone: \_\_\_\_\_ Effective Dates: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

In case of Emergency notify: \_\_\_\_\_ (other than spouse)

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Consulting Physician: \_\_\_\_\_ Last seen: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I HEREBY AUTHORIZE ASSIGNMENT OF BENEFITS TO PHYSICIAN'S PRACTICE GROUP FOR MEDICAL SERVICES RENDERED AND THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Signature of Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

I WILL ASSUME COMPLETED RESPONSIBILITY FOR THE COST OF SERVICES RENDERED REGARDLESS OF MY INSURANCE CONTRACTS INCLUDING DEDUCTIBLES, COPAYS, AND NON-COVERED SERVICES.

Signature of Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_