

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: _____

Number of children Living: _____ Number of miscarriages: _____ Pregnant: _____

Parent or Spouse: _____ SS#: _____
(circle one)

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ County: _____

Age: _____ Date of Birth: _____ Sex: _____

Employer: _____

Phone: _____ Effective Date: _____

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 COMPLETE 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