

For Internal Use Only  
PT ID Number

**Patient Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Maiden or Nickname \_\_\_\_\_  
Street Address \_\_\_\_\_ Apt. \_\_\_\_\_ P.O. Box \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status  Single  Married  Divorced  Widowed  Other  
Home Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Other Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
(Give Form) May we email you?  Yes  No

**Patient's Employer Information**

Employer's Name \_\_\_\_\_ Employer Phone # \_\_\_\_\_  
Patient's Occupation: \_\_\_\_\_ If Student  Full time  Part time School \_\_\_\_\_

**Insurance Information - Primary / Secondary / Other** Do you have health insurance?  Yes  No

**Primary Insurance Company Name** \_\_\_\_\_  
Please indicate the policyholder for the primary insurance:  Self  Parent  Spouse  Other \_\_\_\_\_  
**Secondary Insurance Company Name** \_\_\_\_\_  
Please indicate the policyholder for the secondary insurance:  Self  Parent  Spouse  Other \_\_\_\_\_

**Spouse's Information Or Parent's Information (If Patient is covered by Parent's Insurance)**

Spouse's or Parent's Name \_\_\_\_\_ Spouse's or Parent's Birth Date \_\_\_\_\_  
Spouse's or Parent's SS# \_\_\_\_\_ Employer's Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Spouse's or Parent's Employer \_\_\_\_\_

**Emergency Information: Please list the nearest living relative/friend other than your spouse/parent**

In case of an emergency, we may contact: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
\_\_\_\_\_  
Telephone No. Relationship to Patient

**Other**

Primary Care Physician's Name: \_\_\_\_\_ Primary Physician Name in This Office: \_\_\_\_\_

**Authorization for Treatment, Payment & Healthcare Operations**

I authorize the release of medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to the Center for Advanced Reproductive Medicine, its successors and assigns, or any individual it may designate for services provided.  
As part of this authorization, Center for Advanced Reproductive Medicine will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law.  
I further agree to pay all costs of collection, including attorney's fees, associated with collection of any amount due for services rendered and performed. I will pay interest at the prevailing annual rate for all amounts 30 days past due. I understand that I am financially responsible to the Center for Advanced Reproductive Medicine, its successors and assigns and any individual it may designate for amounts owed by me in accordance with my health benefit coverage.

Signature of Patient or Parent of Minor

Date

**Notice of Privacy:**  Accepted  Refused \_\_\_\_\_

Signature of Patient or Parent of Minor

Date