Patient Information & Contact Numbers

Patient Name: _____ Referred by: _____

Age: _____ Date of Birth: _____ OB-GYN: _____

Status: __ Single __ Married __ Domestic Partners __ Other

Ethnicity: _____ Social Security Number: _____

Occupation: _____

Address:

Street: _____ Suite/Apt. #: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone Numbers: Please check any boxes that we are ***NOT*** to leave messages for you.

- o Home: (_____) _____-_____
- o Work: (_____) _____-_____
- o Cell: (_____) _____-_____
- o Emergency Contact: : Name: _____
  - o (_____) _____-_____

Partner's Name: _____ Phone Number: (__) _____-_____

Age: _____ Date of Birth: _____ Social Security Number: _____

Ethnicity: _____ Occupation: _____

Authorization To Release Information And Authorization To Pay:

1. I hereby authorize the physician and/or nurse at **Innovative Fertility Center** to administer such treatment and medication as may be deemed necessary or advisable in the treatment and diagnosis of my condition. This authorization is given voluntarily and I hereby acknowledge that no guarantees have been made to me as to the results of treatments and examinations at **Innovative Fertility Center**.
2. I hereby authorize **Innovative Fertility Center** to release any information acquired in the course of my examination or treatment to any person or corporation, including but not limited Physicians, Insurance Carriers, Huntington Reproductive Center, laboratories, and hospitals, providing such agent has a financial liability for my treatment at **Innovative Fertility Center**.
3. I hereby give my permission, when applicable, for my Insurance Company to pay **Innovative Fertility Center** directly. I further agree to pay any balance due and payable.
4. I understand that I am responsible, prior to treatment, for inquiring with my Insurance Company as to the benefits of my policy for services provided by **Innovative Fertility Center**.
5. I have read, understand and all questions have been answered and acknowledge that my Health Information is protected and confidential. I have received a copy of Notice of Privacy Practices.

Signature: _____ Date: _____