New Patient Registration – Reproductive Endocrinology and Infertility Group

Please Print

Today's Date:

PATIENT INFORMATION

Full Legal Name: (First) (Middle) (Last)				Email:	
Address: (Number) (Street) (Apt. No.)				Cell Phone:	
City:	State:	Zip:	Social Security Number:	Home Phone:	
Date of Birth:	Age:	Sex:	Marital Status:	Occupation:	
Employer Name:	Street Address:		City:	State:	Zip:
Business Phone: (Including Ext.)			Patients Driver License No.:		State:
Other Physicians You See					
How Did You Here About Us?					

SPOUSE INFORMATION

Full Legal Name: (First) (Middle) (Last)		Occupation:		
Address: (If Diff. From Above)	City:	State:	Zip:	Home Phone:
Employer Address:	City:	State:	Zip:	Business Phone: (Ext)

INSURANCE INFORMATION

Primary Insurance Company Name:	Group No.:	ID/Certificate No.:
Subscriber Name:	Where to Send Claim:	
Secondary Insurance Company Name:	Group No.:	ID/Certificate No.:
Subscriber Name:		

EMERGENCY INFORMATION

Person to Notify In Case Of Emergency		Relationship:	
Address: (Number) (Street)		(Apt. No.)	
City:	State:	Zip:	Home Phone:

INFORMATION FOR THE PATIENT

1. Patients who are self-pay or have nonstandard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. Payment is expected at the time services are rendered from the patient or guarantor.
2. Patients with contract health plans should present their insurance ID cards to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc.) require a copayment or co-insurance that will be collected at the time of service.
3. If you have any questions we will be happy to assist you.

SIGNATURE: