AUSTIN FERTILITY INSTITUTE

PATIENT INFORMATION

Name _____ Home Phone _____

Soc. Sec. # _____ Cell Phone _____

Address _____ E-MAIL:_____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Date of Birth _____ ☐ Single ☐ Married ☐ Other _____

Employer Name _____ Occupation _____

Employer Address _____Work Phone_____

Whom may we thank for referring you? _____If not referred by Doctor, how did you hear about us?_____

OB/GYN Name _____ Phone_____ Fax_____

In case of emergency who should be notified? _____Relation: _____Phone _____

Partner/spouse name:_____DOB:_____SS#:_____

PRIMARY INSURANCE INFORMATION

Insurance Company Name _____ Phone _____

Insurance Address _____

Primary Insured Name _____ Birth date _____

Soc Sec of Insured _____ Relationship to Patient : ☐ Self ☐ Spouse ☐ Other

Insurance ID # _____Group # _____

Employer of Insured _____ Phone _____ Address_____

Other insurance coverage? _____

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at the Houston Fertility Institute?

☐ Appointment cards ☐ Home Telephone ☐ Work phone ☐ Cell phone ☐ _____

If you have an answering machine, may we leave messages regarding appointments, treatment and or information pertinent to your healthcare provided to you: ☐ Yes ☐ No If NO, how else we may contact you regarding information:_____

Please list any other restrictions regarding messages or reminders about your healthcare:_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance coverage with _____ and assign directly to *AUSTIN FERTILITY INSTITUTE* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Patient/Responsible Party Signature Date