

Patient Profile

PATIENT INFORMATION

Patient ID #: _____

Name: _____

Address: _____

City, State: _____

Phone: _____ [] Home [] Cell [] Work

Phone: _____ [] Home [] Cell [] Work

Phone: _____ [] Home [] Cell [] Work

PATIENT EMPLOYER / SCHOOL

[] Employed [] Retired [] Unemployed [X] Other

Phone: _____

Employer: _____

Occupation: _____

SPOUSE/GUARANTOR INFO

Name: _____

Address: _____

City, State: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE

[] Same as Patient [] Same as Spouse [] Other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to patient: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

Drug Allergies: _____

Pharmacy Phone/Name: _____

Dr. License #: _____ State Expires _____

Date of Birth: _____

Social Security #: _____

Marital Status: _____

Referring Physican: _____

E-Mail: _____

May we contact you via email? y n

EMERGENCY CONTACTS

Name Relation to Patient Phone Number

SPOUSE/GUARANTOR EMPLOYMENT

Employer: _____

Occupation: _____

Phone: _____ [] Home [] Cell [] Work

Phone: _____ [] Home [] Cell [] Work

Phone: _____ [] Home [] Cell [] Work

SECONDARY INSURANCE

[] Same as Patient [] Same as Spouse [] Other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to Patient: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

I hereby assign payment of medical benefits to Fertility Specialists of Dallas for all services rendered. I understand that I am financially responsible for all charges, whether or not paid by the above said insurance companies and that payment in full must be made within 30 days of statement billing and that Fertility Specialists of Dallas may send any records necessary to secure payment from the insurance company. Any balances over 90 days old will be turned over to a collection agency and additional fees will accrue. All information provided is true and correct and a copy of this is as valid as the original.

Date _____ Patient Signature _____

Please list people with whom we can discuss your care and leave messages.

1.) _____ Phone Number: _____

2.) _____ Phone Number: _____

May we call/leave messages on your answering machine at home: y n Work: y n Cell: y n (Please understand that if we cannot leave messages, it will be your responsibility to initiate contact with us regarding follow up of lab. appointments, etc)

I have received information regarding the notice of privacy practices from Fertility Specialists of Dallas.

[] I want a copy [] I do not want a copy Patient Signature _____