WASHINGTON FERTILITY CENTER

# *Patient Registration*

## Who Referred You? How Did You Hear About Us? *(please select and specify all that apply)*

☐ Physician*
☐ Self-referred
☐ Internet/Web Site
☐ Insurance Directory
☐ Friend/Other Patient

☐ Television _____
☐ Radio _____
☐ Magazine _____
☐ Newspaper _____
☐ Other _____

*Physician Name _____
Street Address _____
City _____Phone _____
Specialty_____

| Patient | | Partner | |
|---|---|---|---|
| Name (Last, First, Middle Initial) | | Name (Last, First, Middle Initial) | |
| Address | | Address | |
| City/State/Zip | | City/State/Zip | |
| Social Security No. | Cell Phone | Social Security No. | Cell Phone |
| Home Phone | Work Phone | Home Phone | Work Phone |
| Personal Email | Date of Birth - Age | Personal Email | Date of Birth - Age |
| Marital Status | Marriage Date | Marital Status | Marriage Date |

| Patient's Employment | | Partner's Employment | |
|---|---|---|---|
| Company Name | Occupation | Company Name | Occupation |
| Address | | Address | |
| City/State/Zip | | City/State/Zip | |

| Patient's Primary Insurance | | Partner's Primary Insurance | |
|---|---|---|---|
| Insurance Company Name | | Insurance Company Name | |
| Address | | Address | |
| City/State/Zip | | City/State/Zip | |
| Phone | | Phone | |
| Policy Holder Name | | Policy Holder Name | |
| Policy No. | Group No. | Policy No. | Group No. |

| Emergency Contact | | | |
|---|---|---|---|
| Name | Day Phone | Night Phone | Relationship |

## Authorizations

AUTHORIZATION TO PAY BENEFITS TO PHYISICAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described, realizing I am responsible to pay no-covered services. I also realize that I am responsible for any other costs incurred while collecting my outstanding balance(s). I will pay you all costs of collection, including attorney's fees, up to the maximum permitted under applicable law, and other charges, if incurred.

AUTHORIZATION TO RELEASE INFORMATION: I Hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

| Patient | | Partner | |
|---|---|---|---|
| Signed (Patient or Parent if Minor) | Date | Signed (Patient or Parent if Minor) | Date |