fertilitycenter
MyFertilityCenter.com

Date _____

Name of Referring Physician: _____

Name of OB/GYN: _____

PATIENT INFO

_____ _____ _____ _____

Last First Middle Date of Birth

Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Seperated ☐

Social Security # _____ Driver's License # _____

Home Address: _____

Street Address City State Zip

Home Phone _____ Ok to Leave a Message? ☐ YES ☐ NO

Work Phone _____ Ok to Leave a Message? ☐ YES ☐ NO

Cell Phone _____ Ok to Leave a Message? ☐ YES ☐ NO

Email Address: _____ Ok to Send Emails? ☐ YES ☐ NO

*No medical history is sent in Text Messages *Text Messages? ☐ YES ☐ NO

Occupation _____ Employer _____

Work Address: _____

Street Address City State Zip

SPOUSE/PARTNER INFO (or if minor, PARENT/GUARDIAN)

_____ _____ _____ _____

Last First Middle Date of Birth

Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Seperated ☐

Social Security # _____ Driver's License # _____

Home Phone _____ Ok to Leave a Message? ☐ YES ☐ NO

Work Phone _____ Ok to Leave a Message? ☐ YES ☐ NO

Cell Phone _____ Ok to Leave a Message? ☐ YES ☐ NO

Email Address: _____ Ok to Send Emails? ☐ YES ☐ NO

*No medical history is sent in Text Messages *Text Messages? ☐ YES ☐ NO

Occupation _____ Employer _____

Work Address: _____

Street Address City State Zip

TURN PAGE OVER

INSURANCE INFORMATION

Insured Name _____ _____
Last First Middle Date of Birth

Insured Social Security _____ Relationship to Patient _____
Insured Party Employed by _____ Business Phone _____

Subscriber ID: _____ Group Number _____
Insurance Company _____ Phone (Provider Svcs) _____
Insurance Address _____
Address (Mail Claims to) City State Zip

Are you on your spouse/partner's insurance? ☐ YES ☐ NO

ADDITIONAL INSURANCE

Insured Name _____ _____
Last First Middle Date of Birth

Insured Social Security _____ Relationship to Patient _____
Insured Party Employed by _____ Business Phone _____

Subscriber ID: _____ Group Number _____
Insurance Company _____ Phone (Provider Svcs) _____
Insurance Address _____
Address (Mail Claims to) City State Zip

Are you on your spouse/partner's insurance? ☐ YES ☐ NO

ASSIGNMENT AND RELEASE

PAYMENT: *I understand that payment is due when service is rendered, and proof is required to show that an annual deductibe has been met. Also, it is my responsibility to obtain any required referrals prior to my appointment and report any changes in personal or insurance information.*

ASSIGNMENT: *I hereby assign my insurance benefits to be paid directly to the physician. I am financially responsible for non-covered services. I hereby authorize the release of any medical information necessary.*

Patient or Authorized Signature_____ **Date**_____

Partner or Authorized Signature_____ **Date**_____

PLEASE HELP US

How did you hear about us (circle all that apply): Website/Internet Referring Physician

Family/Friend Print Ad Fertility Authority Other _____

If a family/friend or referring physician, please list name _____

Dr. Bird and Dr. Donesky serve as faculty members at UT College of Medicine and are committed to sharing their expertise with future physicians. Residents and medical studens are often present during patient exams and procedures at the Fertility Center. While your cooperation is appreciated, please know that the quality of your care will not be impacted if you prefer that residents and medical students not be involved during your visit(s). If you are uncomfortable with doctors-in-training during your appointment, let one of our staff know. Thank you.