West Valley Fertility Center

PATIENT DEMOGRAPHICS

(Please Print Clearly)

Patient's Full Name: First MI Last	**SS# :** - -
	DOB: **AGE:**
	SEX: F M **ETHNICITY:**
Street Address: **Apt #**	**Marital Status:**
City: **State:** **Zip:**	Single Married Domestic Partner
Home Phone ( ) **Work Phone ( )** **Ext:**	**Cell Phone ( )**
Partner's Full Name: First MI Last	**SS# :** - -
	DOB: **AGE:**
	SEX: F M **ETHNICITY:**
Street Address: Same as above: ( ) **Apt #**	**Marital Status:**
City: **State:** **Zip:**	Single Married Domestic Partner
Home Phone ( ) **Work Phone ( )** **Ext:**	**Cell Phone ( )**

Name of Referring Physician? **(Please give first and last name)**	**Phone ( )**

How did you hear about our facility… **(Please circle one)**	Doctor/Nurse	Friend/Family	Internet/Website
	Patient	Insurance Co.	Yellow Pages
	ARC		Other:

Guarantor/Insurance Information *(complete only if the insurance policy holder **is not** the patient)*

Guarantor Full Name: First MI Last	**SS# :** - -
	DOB:
Street Address: **Apt #**	**Realtionship to Patient:** _____
City: **State:** **Zip:**	
Home Phone ( ) **Work Phone ( )** **Ext:**	**Cell Phone ( )**

Financial and Insurance Information

PRIMARY Insurance:	**Subscriber Name:**
Policy #	**Group #**
SECONDARY Insurance:	**Subscriber Name:**
Policy #	**Group #**

(complete only if the emergency contact is not your partner listed above)		
EMERGENCY CONTACT:	**PHONE ( )**	**RELATIONSHIP TO PATIENT:**

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to my physician and authorize the release of any information requried to process claims. I understand that if my account goes to a collection agency that I will be responsible for any and all fees in connection with such agency and/or legal counsel. I also understand that regardless of my insurance that I will be financially responsible for all services rendered.

Signed: _____ **Realtionship:** _____ **Date:** _____