

West Valley Fertility Center
PATIENT INFORMATION PLEASE PRINT

Please provide us with the following information and/or make any needed changes:

Patient Full Name: First MI Last			DOB: _____	Age: _____
Address: Street Apt#			Home Phone: () ()	
City State Zip			Work Phone: () ()	
Employer: Name City			Cell Phone: () ()	
			Social Security # _____ - _____ - _____	
Partner's Full Name: First MI Last			DOB: _____	Age: _____
Address: <input type="checkbox"/> same as above Street Apt#			Home Phone: () () <input type="checkbox"/> same as above	
City State Zip			Work Phone: () ()	
Employer: Name City			Cell Phone: () ()	
			Social Security # _____ - _____ - _____	

Name of your Primary Care Provider?	Phone: () ()
Name of your Referring Physician?	Phone: () ()
Please tell us how you heard about our facility...	
<input type="checkbox"/> Referring Physician	<input type="checkbox"/> Mailer
<input type="checkbox"/> Previous Patient (self)	<input type="checkbox"/> Yellow Pages
<input type="checkbox"/> Friend / Family	<input type="checkbox"/> Seminar: _____
<input type="checkbox"/> Advertisement: _____	<input type="checkbox"/> Nurse: _____
<input type="checkbox"/> OBGYN: _____	<input type="checkbox"/> Urologist _____
<input type="checkbox"/> Insurance Referral	<input type="checkbox"/> T.V.
<input type="checkbox"/> Web Site www. _____	<input type="checkbox"/> Pharmacist _____
<input type="checkbox"/> Other _____	

Guarantor/Insurance Information <i>(complete if the insurance policy holder is not the patient)</i>	
Guarantor Full Name: First MI Last	Day Phone: () ()
Guarantor Address: Street Apt#	Social Security # _____ - _____ - _____
City State Zip	Relation to patient: _____ DOB: _____

Financial and Insurance Information	
PRIMARY insurance:	Subscriber:
Policy #:	Group #:
SECONDARY Insurance:	Subscriber:
Policy #:	Group #:

Emergency Contact:	Phone: () ()
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ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to my physician and authorize the release of any information required to process my 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 or legal counsel. I also understand that regardless of my insurance that I will be financially responsible for all services rendered.

SIGNED: _____ **RELATIONSHIP:** _____ **DATE:** _____