

**MIDWEST REPRODUCTIVE CENTER, PA**

~Patient Registration Form~

Date: \_\_\_\_\_

**Patient's Name:** (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status: (check one) Single ( ) Divorced ( ) Married ( ) Separated ( )

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Email: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home phone: ( ) - \_\_\_\_ - \_\_\_\_ Work phone: ( ) - \_\_\_\_ - \_\_\_\_ Cell phone: ( ) - \_\_\_\_ - \_\_\_\_

Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_

**Emergency Contact Name & Address:** \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

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Referred by: Friend ( ) Insurance ( ) Physician ( ) Other ( ) Specify: \_\_\_\_\_

Current Family Practice or OB/GYN physician: \_\_\_\_\_

Phone: ( ) - \_\_\_\_ - \_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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**Spouse's Name:** (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_ Age: \_\_\_\_\_

Spouse's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Spouse's Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

Spouse's occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Spouse's work phone: ( ) - \_\_\_\_ - \_\_\_\_

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**INSURANCE INFORMATION:** (Please include a copy of front and back of your insurance card) (If you have a secondary insurance, please list on back of page)

Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_

Group Number: \_\_\_\_\_ Plan Number: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**Consent to Treat\*Assignment of Benefits\*Financial Agreement**

While I am here, I permit the employees, the physician, and other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending physician will explain to me the nature of my condition and his recommended treatment and any associated risk involved. I also understand that he will explain to me other ways this condition could be treated. I further understand that this care may include tests, examinations, medical and/or surgical treatment. No guarantees have been made to me about the outcome of this care.

I authorize MIDWEST REPRODUCTIVE CENTER, PA, to release to the insurance carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim be made directly to MIDWEST REPRODUCTIVE CENTER, PA.

I understand that that I am financially responsible for all services received regardless of insurance payment or denial. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I understand that if I fail to obtain an authorization from my Primary Care Physician, where applicable, that I am solely responsible for payment of all charges.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_