MIDWEST REPRODUCTIVE CENTER, PA

~Patient Registration Form~

Date: _____

Patient's Name: (Last)_____ (First) _____ (M.I.) _____ Age: _____

Marital Status: (check one) Single ( ) Divorced ( ) Married ( ) Separated ( ) Ethnicity/Race: _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____ Email: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home phone: ( ) - _____ - _____ Work phone: ( ) - _____ - _____ Cell phone: ( ) - _____ - _____

Occupation: _____ Employer Name: _____

Emergency Contact (other than partner**) Name & Address: _____**

Phone: _____ Relationship to patient: _____

Pharmacy name _____ Pharmacy address _____

Referred by: Friend ( ) Insurance ( ) Physician ( ) Other ( ) Specify: _____

Current Family Practice or OB/GYN physician: _____

Phone: ( ) - _____ - _____ Address: _____

City: _____ State: _____ Zip Code: _____

Spouse/Partner's Name: (Last) _____ (First) _____ (M.I.) _____ Age: _____

Spouse/Partner's Date of Birth: _____/_____/_____ Spouse/Partner's Social Security Number: _____-_____-_____

Spouse/Partner's occupation: _____ Employer Name: _____

Spouse/Partner's work phone: ( ) - _____ - _____ Spouse/Partner's cell phone: ( ) - _____ - _____

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# _____

Insurance Type: (circle one) PPO HMO POS EPO EPP Customer Service Phone # _____

Group Number: _____ Plan Name: _____

Claims Mailing Address: _____

Primary Card Holder Name: _____ Relationship: _____

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

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**: _____