



PATIENT APPLICATION FORM

(Please Print Clearly)

Today's Date:		Reproductive Endocrinologist:	
CLIENT INFORMATION			
Last Name:	First:	Middle:	<input type="radio"/> Mr. <input type="radio"/> Mrs. <input type="radio"/> Miss <input type="radio"/> Ms.
Is this your legal name? <input type="radio"/> Yes <input type="radio"/> No			<input type="radio"/> Single <input type="radio"/> Married
If not, what is your legal name?			<input type="radio"/> Divorced <input type="radio"/> Separated
(Former name):			<input type="radio"/> Widow
Birth date:	Age:	<input type="radio"/> Male <input type="radio"/> Female	
Street address:	P.O. box:		
City:	State:	ZIP Code:	
Home phone no.: ()		Cell phone no.: ()	
Social Security no.:		Occupation:	
Employer:		Employer phone no.: ()	
Chose clinic because/referred to clinic by (Please check one box):			
Dr.		<input type="radio"/> Insurance plan <input type="radio"/> Hospital	
<input type="radio"/> Family <input type="radio"/> Friend <input type="radio"/> Close to home/work <input type="radio"/> Yellow Pages <input type="radio"/> Other			
Other family members seen here:			
INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for bill:		Birth date:	
Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="radio"/> Yes <input type="radio"/> No			
Occupation:		Employer:	
Employer address:		Employer phone no.: ()	



Is this patient covered by insurance? <input type="radio"/> Yes <input type="radio"/> No	
Please indicate primary insurance: <input type="radio"/> Insurance <input type="radio"/> Welfare (Please provide coupon) <input type="radio"/> Other	
Subscriber's name:	Subscriber's S.S. no.:
Birth date:	Group no.:
Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other	
Name of secondary insurance (if applicable):	
Subscriber's name:	
Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other	
IN CASE OF EMERGENCY	
Name of local friend or relative (not living at same address):	
Relationship to patient:	
Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.	
Patient/Guardian signature	Date