

PATIENT REGISTRATION FORM

Male's Full Name: First Middle Last	Home Phone: Please include Area Code		
Home Address:	Date of Birth:		
	Soc. Sec. #:		
Employer:	Work Phone: Please include Area Code		
Alternate Phone Number: Please circle: Cell Pager Other:	Marital Status: Single Married		
	If married, how long?		
<p><i>I AUTHORIZE THIS OFFICE TO CALL ME AT _____ (phone #) between the hours of 7:30AM - 4:00PM to discuss lab results and review my cycle plan.</i></p> <p style="text-align: center;"><i>The best time to reach me at this phone # is</i></p>			
<p><i>I AUTHORIZE THIS OFFICE TO DISCUSS MY RESULTS AND/OR MY CYCLE PLAN WITH THE FOLLOWING PERSON:</i></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 60%; text-align: center;">Name of Partner/Person</td> <td style="width: 40%; text-align: center;">Relationship</td> </tr> </table> <p><i>You may reach this person best by calling _____ (phone #), and the best time to call is _____.</i></p>		Name of Partner/Person	Relationship
Name of Partner/Person	Relationship		
Family Physician (PCP): _____ Phone #: _____			
Address: _____ Code Street City, State Zip			
Referring Physician: _____ Phone #: _____			
Address: _____ Code Street City, State Zip			
<p>INSURANCE INFORMATION: COPIES OF ALL INSURANCE CARDS ARE NEEDED ON FILE.</p> <p>Male: Primary _____ Secondary _____</p> <p>I certify this information is true and correct to the best of my knowledge. The Fertility Center, LLC has my authorization to adhere to my consents outlined on this form. My signature below also authorizes information to be released to my physicians listed above (i.e. primary care physician and/or OB/GYN physician).</p>			
Guarantor Signature (Male): _____ Date: _____			