Midwest Fertility Specialists

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Today's Date_____

PATIENT INFORMATION (please print) EMAIL:_____

Patient's legal name _____ Nickname _____
(last) (first) (MI)

Date of birth _____ Age _____ Martial Status S M D W Social Security # _____

Street Address_____ Cell Phone _____

City/State/Zip _____ Home Phone _____

Employer _____ Work Phone_____

Name of partner/parent (circle one) _____Date of birth_____ Age_____
(last) (first) (MI)

Phone_____Social Security #_____

Employer _____Work Phone _____Cell Phone_____

Partner's street address,
if different from above _____ City/State/Zip _____

Emergency Contact
Other than partner _____ Phone _____

StreetAddress _____ City/State/Zip_____

PREFERRED PHARMACY NAME AND PHONE:_____

INSURANCE INFO:

Person responsible for payment (if not patient)_____Relationship_____Home Phone_____

Primary Insurance Co _____ Effective Date _____ Policy No _____

Insurance Mailing Address _____City/State/Zip _____

Secondary Insurance Co _____Effective Date _____ Policy No _____

Insurance Mailing Address _____City/State/Zip _____

REFERRAL INFORMATION:

Are you being referred by another physician, family member, or friend? NO YES IF YES, who?_____

IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED. ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT.
THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

INSURANCE AUTHORIZATION (PLEASE READ AND SIGN)

I hereby authorize Midwest Fertility Specialists to furnish Insurance companies, or their representatives, information concerning my, or my dependent's illness and treatments. I hereby assign to Midwest Fertility Specialists all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance and agree to pay for any collection and/or attorney fees if said reimbursement amounts are not paid within a reasonable time period.
My signature also acknowledges that I have been given the opportunity to review Midwest Fertility Specialist privacy notice disclosure.

_____Date_____ _____Date_____
(Signature of PATIENT) (Signature of PARTNER OR PARENT)