



**PATIENT ACCOUNT INFORMATION**

**PATIENT**

Patient Full **LEGAL** Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Marital Status:          Single          Married          Divorced          Widowed          Domestic Partner

Primary Physician/Internist \_\_\_\_\_ Ob/Gyn: \_\_\_\_\_

Employer Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Drivers License/ID # \_\_\_\_\_ Email \_\_\_\_\_

Preferred method of communication?    Email          Home          Work          Cell          OK to leave message

**HUSBAND/PARTNER**

Full **LEGAL** Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse's Social Security \_\_\_\_\_ Spouse's Contact Phone \_\_\_\_\_

*(if spouse is the insured)*

Does your insurance company cover fertility testing and treatment?    Yes    No

**PRIMARY INSURANCE INFORMATION**

Insurance Company Name \_\_\_\_\_ HMO    PPO    Private

Claims Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient:    Self    Spouse

Insured Employer Name: \_\_\_\_\_

Insurance I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Insurance Company Name \_\_\_\_\_ HMO    PPO    Private

Claims Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient:    Self    Spouse

Insurance I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name of Person to Contact \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_



## PATIENT FINANCIAL RESPONSIBILITY

Please initial each statement:

\_\_\_\_\_ Payment is due at the time services are rendered.

\_\_\_\_\_ I hereby assign my insurance benefits to be made directly to Sharon E. Moayeri, M.D., Inc. and/or OC Fertility and any assisting physicians for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company.

\_\_\_\_\_ I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original.

\_\_\_\_\_ All charges are the direct responsibility of the patient.

\_\_\_\_\_ I understand that services cannot be rendered on the assumption that charges will be paid by the Insurance Company and that insurance is an agreement between me and my insurance company.

\_\_\_\_\_ I hereby acknowledge that I have read, understand and agree to hereby give consent to access, treat and test.

Name (Please Print): \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date \_\_\_\_\_