fertility

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_____