

# UNIVERSITY OB/GYN ASSOCIATES FERTILITY CENTER

## PATIENT INFORMATION

Name	Today's Date
Address	D.O.B.                      SS#
City/State/ZIP	Marital Status (circle) M S W D
Phone-home	Employer's Name
Phone-work	Employer's Address
Work Hours/Days	City/State/ZIP
Referred By	Address
Phone	City/State/Zip
Partner/Spouse Name	D.O.B.                      SS#
Address	Employer's Name
City/State/Zip	Employer's Address
Phone-home	City/State/Zip
Phone-work	Work Hours/Days
Emergency Contact	Relationship                      Phone#
Primary Insurance Company	Subscriber
Membership/ID#	
Group/Plan#	
Phone # for Verification/Claims	
Billing Address	City/State/ZIP
Effective Date Policy/Card	Expiration Date Card
Secondary Insurance Company	Subscriber
Membership/ID#	
Group/Plan #	
Phone # for Verification/Claims	
Address	City/State/ZIP
Effective Date Policy/Card	Expiration Date Card

**PLEASE COMPLETE ALL INSURANCE INFORMATION-COPY CARD FRONT & BACK**

**Authorization to Release Information and Assignment of Benefits to University OB/GYN Associates**

I authorize University OB/GYN Associates to furnish all information available to insurance carriers concerning my illness and/or treatments to process claims.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby assign to University OB/GYN Associates benefits from my insurance company paid directly to them.

I understand that I am responsible for charges within 30 days of being billed and am subject to 1.5% interest per month on the unpaid balance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**ALLERGIES**                      (Medicines,                      foods,                      plants,                      animals)                      What                      Happens?