

**NEW PATIENT**

**INFORMATION**

DATE \_\_\_\_\_ REFERRAL SOURCE \_\_\_\_\_

NAME \_\_\_\_\_  
(Last) (First) (MI)

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

\_\_\_\_\_  
(CITY) (STATE) (ZIP)  
 HOME TELEPHONE (\_\_\_\_\_) WORK TELEPHONE (\_\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

EMPLOYER \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

\_\_\_\_\_  
(CITY) (STATE) (ZIP)  
 TELEPHONE NUMBER (if different from above) (\_\_\_\_\_) \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ TELEPHONE (\_\_\_\_\_) \_\_\_\_\_

PARTNER'S NAME \_\_\_\_\_  
(Last) (First) (MI)

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

EMPLOYER \_\_\_\_\_ TELEPHONE (\_\_\_\_\_) \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

\_\_\_\_\_  
(CITY) (STATE) (ZIP)

PRIMARY INSURANCE CARRIER \_\_\_\_\_

INSURED \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ID NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

SECONDARY INSURANCE CARRIER \_\_\_\_\_

INSURED \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ID NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

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I authorize the release of any medical records or other information necessary to process my medical claims.

\_\_\_\_\_  
 PATIENT'S SIGNATURE DATE SPOUSE'S/PARTNER'S SIGNATURE DATE

I authorize payment of medical benefits to IVF Phoenix for any or all medical services performed.  
 I understand that I am financially responsible for the charges not covered by my insurance.

\_\_\_\_\_  
 PATIENT'S SIGNATURE DATE SPOUSE'S/PARTNER'S SIGNATURE DATE

I authorize release of any and all information pertaining to me in this office to my spouse/partner.

\_\_\_\_\_  
 PATIENT'S SIGNATURE DATE SPOUSE'S/PARTNER'S SIGNATURE DATE