

## Patient Information

<b>Patient Information</b>				
Last Name		First Name		MI
Address		City	State	Zip
Date of Birth	Social Security No.	Driver's License No.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	
Home Phone (   )	Work Phone (   )	Cell Phone (   )	E-Mail (separate consent required)	
Referring Physician's Name			Referring Physician's Phone No. (   )	
Referring Physician's Address		City	State	Zip
Occupation			Employer Name	
Employer Address		City	State	Zip
Name of Spouse/Partner		Date of Birth	Social Security No.	
Occupation	E-Mail (separate consent required)	Work Phone (   )	Cell Phone (   )	
Nearest Relative Not Living in Household		Relationship	Home Phone (   )	
Address		City	State	Zip

I understand that Ovation Fertility is not contracted with all insurance companies or any government sponsored health plans, such as Medicare, Medicaid, or Tricare and that payment in full is due at the time of service unless otherwise advised. I understand that upon request, Ovation Fertility will submit a claim to my insurance company (excluding any government sponsored health plans) as a courtesy, and I acknowledge that it is my responsibility to contact them regarding the status of any claims submitted on my behalf. I authorize the release of any medical records or other information necessary to process my claim. By providing the above information, I have consented to be contacted by Ovation Fertility at any of the above addresses or telephone numbers. I further agree that a photocopy of this agreement is as valid as the original.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Partner Signature: \_\_\_\_\_ Date: \_\_\_\_\_