Fort Worth Fertility, PA
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1800 Mistletoe Blvd
Fort Worth, TX 76104

PATIENT REGISTRATION FORM

(PLEASE PRINT)

Patient Name:_____ ___ _____Partner Name:_____
First Name *M.I.* *Last Name*

Marital Status: ____ Married for ____ years ____ Engaged ____ Single ____ In a same-gender relationship for ___ years

Patient SSN: _____ Partner SSN: _____

Patient Occupation: _____ Partner Occupation: _____

Patient D.O.B.: _____Partner D.O.B.: _____

Patient Race: _____Partner Race: _____

Home Phone: _____

Patient Cell Phone: _____

Patient Work Phone: _____ Partner Work Phone: _____

Billing Address: _____

Patient Confidential E-mail Address: _____

EMERGENCY CONTACT

Nearest relative or partner: _____

Phone Number(s): _____

Authorization to Release Information: I authorize the release of any medical records or other information to process my health claim. **Authorization for payment:** As a condition for treatment by this office, I understand that the practice depends upon reimbursement from the patients for the costs incurred in their care. Care is to be paid for at the time of service. If I carry insurance, I understand that this office will HELP in obtaining prior authorization; however, it is my responsibility to ensure that authorization is in place for my services as needed. If authorization is not received prior to my appointment, I am responsible for payment. Any services not covered by my insurance company will be my financial responsibility.

Printed Name: _____Signature _____Date _____