# San Antonio IVF

## Patient Information

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|---|---|---|---|---|
| Last Name | First Name | | | MI |
| Address | City | | State | Zip |
| Date of Birth | Social Security No. | Driver's License No. | Marital Status ☐Single ☐Married ☐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 | Employer Name | Work Phone ( ) | Cell Phone ( ) | |
| Nearest Relative Not Living in Household | | Relationship | Home Phone ( ) | |
| Address | City | | State | Zip |

I understand that San Antonio IVF 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, San Antonio IVF 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 San Antonio IVF 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:_____

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