Date________________ Marital Status M____S____D____W____

Name_____________________________________________________________
Last (As identified by your insurance company) First M initial

Address_____________________________________________________Apt #:______________

City____________________________________State_______________________Zip____________

Age__________Date of Birth__________________________SS number______________________

Cell #:___________________work #_________________Home#_____________________

Employer:______________________________Occupation__________________________________

Email Address:______________________________________________________________________

Husband/Partner/Parent______________________________________________________ Male/Female
Circle one Name social security number Circle one

Date of birth______________________Employer________________________________________

Emergency contact__________________________________________relationship_______________

Phone numbers______________________________________________________________________
Cell Other

Insurance-Are you the policyholder: ☐ Yes ☐ No Insurance Co_________________________

If no, who is the policyholder and your relationship to the policyholder (parent, spouse, other)

___________________________________________________________________________
Name date of birth Social Security number

If yes, is your partner covered under your policy? ☐ Yes ☐ No

If no, Insurance company of Partner______________________________Please provide card

Referred by:____________________________________________________________________

I,________________________________(Patient/________________________________(partner)
authorize the release of any medical information necessary to process medical claims submitted to my insurance company.

I,________________________________(Patient/________________________________(partner)
authorize payment of medical benefits to the physician or supplier of the medical service.

I,________________________________(Patient/________________________________(partner)
stand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. The filing of insurance claims is a courtesy extended to our patients. I understand that it is my responsibility to determine my financial liability as it pertains to "in" or "out" of network and to secure referrals and/or authorizations, if needed, prior to any services being rendered.

I,________________________________(Patient)/________________________________(partner)
authorize the Fertility Institute of New Orleans to discuss my medical treatment with my family/friend(s) listed below.

___________________________________________________________________________
Name Relationship Name Relationship

************************************************************office use only**************************************

Patient number__________________________ Dr__________________________

Revised 6/20/17