Pacific In Vitro Fertilization Institute

Initial Consult Date_____
Request Confidential Mailings: ☐

PATIENT INFORMATION

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone: ( ) _____ - _____ Date of Birth: _____ Male ☐ Female ☐

Social Security: _____ Student Status: Full Time ☐ Part Time ☐

Occupation: _____ Employer: _____

Work Address: _____

City, State, Zip: _____

Work Phone: ( ) _____ - _____ ext ____ Cell Phone: ( ) _____ - _____

Marital Status: Single ☐ Married ☐ Other ☐ E-mail: _____

Referred By: _____ Physician's Name_____

Ethnicity Code: _____
(See chart of bottom of page)

Physician's Address: _____

Physician's Phone Number: _____

INSURANCE INFORMATION:

Insurance Company: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Policy Number: _____

Subscriber's Sex: M ☐ F ☐ Subscriber's Relationship to patient: _____

Insurance Company: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Policy Number: _____

Subscriber's Sex: M ☐ F ☐ Subscriber's Relationship to patient: _____

If subscribers address is different from patient, please fill out below:

Address _____

City, State, Zip: _____

Phone ( ) _____

**Ethnicity Code: (List number of racial/ethnic group that you most closely identify with):		
1 American Indian or Alaska Native	**3** Black or African American	**5** Hawaiian or Pacific Islander
2 Asian	**4** Hispanic or Latino	**6** Caucasian

PARTNER INFORMATION:

Patient Name: _____ Married to Patient: ☐ Yes ☐ No

**Ethnicity: _____ Social Security: _____ Date of Birth: _____

Occupation: _____ Employer: _____

Work Phone: ( ) _____- _____ext ____ Cell Phone: ( )_____ - _____

Work Address: _____How long employed?_____

Physician(s): _____ Address: _____

How Long? _____ Physician Phone:( ) _____

Emergency Contact: _____

Relationship: _____ Phone: ( ) _____

Referred By: _____ Physician's Name_____

Ethnicity Code: _____ Physician's Address: _____

Insurance Company: _____ Physician's Phone Number: _____

Policy Number: _____

I authorize release of confidential medical information to the following contact persons:

Name: _____ Name: _____

Phone: ( ) _____ Phone: ( ) _____

Relationship: _____ Relationship: _____

I verify that the above information is correct. I understand that I am financially responsible for all charges, regardless of insurance coverage. I request that payment of insurance benefits be made on my behalf to: Pacific In Vitro Fertilization Institute for any services furnished to me.

Signature of Patient:_____ Date: _____

I authorize Pacific In Vitro Fertilization Institute to disclose/request my health information including copies of records as necessary to/from:

1. *Any health insurance plan, company of billing service that provides insurance coverage for me for the purpose of payment of charges.*
2. *Consulting and treating physicians, diagnostic facilities, labs, radiology/imaging, outpatient facilities and hospitals and other health providers for the purpose of continuity of care.*
3. *Any insurance company that provides liability insurance coverage for Pacific In Vitro Fertilization Institute to evaluate clinical performance.*

All medical information with no exceptions will be disclosed/requested as necessary to/from the above. I authorize faxing of information as necessary. This authorization shall cover the period of time from my first visit to my last visit and will end 2 years after the date of my last visit. I permit a copy of this authorization to be used in place of the original.

Signature of Patient:_____ Date: _____