Pacific In Vitro Fertilization Institute

Initial Consult Date____________________
Request Confidential Mailings: ☐

PATIENT INFORMATION

Patient Name: ____________________

Address: ____________________

City, State, Zip: ____________________

Phone: ( ) ______ - __________________ Date of Birth: Month _____ Day_____ Year _______

Social Security: ____________________ Female: _____ Male: _____

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: ____________________

EMERGENCY CONTACT NAME: ____________________

Phone Number: ____________________ Relationship: ____________________

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: ___________________________

Name: _______________________________ Married to Patient: ☐ Yes ☐ No

Social Security: _______________________________ Date of Birth: _________________

Occupation: _______________________________ Employer: _______________________________

Work Phone: ( ) _____- _____________ Cell Phone: ( )______ - ____________________

Work Address: ____

Physician(s): _______________________________ Address: _______________________________

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.

Patient Name: ____

Signature of Patient:____ Date: ________________________