



Patient Registration

Today's Date: _____

Ver 9/22/08

Patient's Name:	Spouse/Partner's Name:
Birth date: Age:	Birth date: Age:
Social Security #	Social Security #
Occupation: _____ Employer: _____	Occupation: _____ Employer: _____
Home Address: _____	<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
City/State/ Zip: _____	<input type="checkbox"/> Remarried <input type="checkbox"/> Single in a committed relationship
Email address: _____	

Referral Source:

Physician _____ Patient/Friend/Relative _____ Other _____

Radio: 96.9 (The Mix) 98.7 (The Peak) 107.3 (KMLE) 99.9 (KEZ) TV _____

Internet: Google Yahoo Pregnancy Info Locate-A-Doc Fertility Doc Shop Fertility Life Lines Other _____

Print: 101 North MD News Phoenix Mag Airpark News AZ Foothills Other _____

Contact List:	Call Order	OK to call	OK to leave detailed message
Home Phone:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Work Phone:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cell Phone:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse/Partner:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Responsible Party/Insurance Subscriber's Name:	Date of Birth:
Address:	Home Tel #:
City, State, Zip:	Work Tel #:

Primary Insured's Ins. Plan:	Secondary Ins. Plan:
Insurance Address:	Insurance Address:
City, State, Zip:	City, State, Zip:
Plan ID #: Group #:	Plan ID #: Group #:
Co-Pay:	Co-Pay:

Local Pharmacy Name:	Phone #:	Fax #:
-----------------------------	-----------------	---------------

Under HIPPA Guidelines, I authorize you to discuss my protected health information for any purpose with the following person(s):

Name : _____ Relationship: _____ Phone Number: _____

I agree that the above information is correct as listed or changed as indicated. I authorize my insurance company to make payments directly to Advanced Fertility Care, PLLC (AFC). I further authorize AFC to release any information about my medical care to my insurance company. This includes diagnosis, treatment and other information contained within the medical record. I agree to pay for any medical services that are not covered under my insurance.

Date _____ Signature _____