

NORTHEASTERN OHIO FERTILITY CENTER
PATIENT INFORMATION SHEET

NAME _____ SOCIAL SECURITY # _____ - _____ - _____
ADDRESS _____ HOME PHONE # _____ - _____ - _____
CITY _____ STATE _____ ZIP _____
EMPLOYER _____ WORK PHONE # _____ - _____ - _____
DATE OF BIRTH ____ / ____ / ____ E-MAIL ADDRESS _____
NAME (HUSBAND) _____ SOCIAL=SECURITY# _____ - _____ - _____
EMPLOYER _____ WORK PHONE # _____ - _____ - _____
DATE OF BIRTH ____ / ____ / ____ E-MAIL ADDRESS _____

WIFE'S INSURANCE COMPANY

HUSBAND'S INSURANCE COMPANY

NAME _____

NAME _____

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

IDENTIFICATION NUMBER _____ GROUP NUMBER _____

IDENTIFICATION NUMBER _____ GROUP NUMBER _____

PHONE NUMBER _____

PHONE NUMBER _____

OFFICE VISIT COPAY?: YES ___ NO ___

OFFICE VISIT COPAY?: YES ___ NO ___

IF YES, WHAT AMOUNT?: \$ _____

IF YES, WHAT AMOUNT?: \$ _____

*****SHOULD A REFERRAL BE NEEDED FOR INSURANCE REIMBURSEMENT, BE SURE TO CONTACT YOUR PRIMARY CARE PHYSICIAN TO ARRANGE ONE AND HAVE A COPY SENT TO OUR OFFICE.*****

REFERRED BY: PRIMARY CARE PHYSICIAN ___ OB GYN ___

PRIMARY CARE/REFERRING PHYSICIAN INFORMATION:

NAME _____ PHONE # _____ - _____ - _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

IN CASE OF EMERGENCY: (List at least two)

NAME: _____

ADDRESS: _____

RELATIONSHIP: _____ PHONE: _____

NAME: _____

ADDRESS: _____

RELATIONSHIP: _____ PHONE: _____

NAME: _____

ADDRESS: _____

RELATIONSHIP: _____ PHONE: _____

Authorization to Release Information: I hereby authorize the above named physician to release all Medical Records and other information with respect to myself or my dependents which may have a bearing on the benefits payable for this claim.

Authorization to Pay Insurance Benefits: I hereby authorize payment directly to the above named facility of the benefits and Physicians' benefits otherwise payable to me but not to exceed the regular charges for this period of treatment. I understand I am financially responsible for charges not covered by this authorization.

When Medicare Benefits Are Applicable: Patients Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social security Act is correct. I authorize any holder of medical or other information or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

SIGNATURE (Female)

DATE

SIGNATURE (Male)

DATE