Central Georgia Fertility Institute

PATIENT INFORMATION

Today's Date ___/___/___ **Date of Birth** ___/___/____ **SS#** ____ - ____ - _____

Patient's Name _____
First Middle Last

Address: _____

City: _____ **State** _____ **ZIP:** _____ **County:** _____

Home Phone: (____) ____ - _____ **Pager/Cell #:** (____) ____ - _____ **Work Phone** (____) ____ - _____

Marital Status: _____ **Race:** _____ **Sex:** ____ **E-Mail Address:** _____

Employer Name: _____ **Employer Phone** (____) ____ - _____

Employer Address: _____

Last Grade of Education Completed _____

Do you have a Living Will / Advanced Directives? YES ☐ NO ☐
If no, do you wish to speak to someone about a Living Will / Advanced Directives? YES ☐ NO ☐

Have you verified fertility benefits with your insurance company? YES ☐ NO ☐

Emergency Contact: _____ **Phone #** (____) ____ - _____

PATIENT INSURANCE INFORMATION

Primary Insurance Name: _____

Address: _____
Phone #: (____) ____ - _____ **Insured's Relationship to Patient:** _____
Insured's Name: _____ **Insured's Date of Birth:** _____/____/_____
Policy #: _____ **Group #:** _____
Insured's Employer: _____ **Employer Phone:** (____) ____ - _____
Employer Address: _____

Secondary Insurance Name: _____
Address: _____
Phone #: (____) ____ - _____ **Insured's Relationship to Patient:** _____
Insured's Name: _____ **Insured's Date of Birth:** _____/____/_____
Policy #: _____ **Group #:** _____
Insured's Employer: _____ **Employer Phone:** (____) ____ - _____
Employer Address: _____

SPOUSE / PARTNER'S INFORMATION

Today's Date ___ /___ /___ Date of Birth ___/___/____ SS# ____ - ____ - _____

Spouse / Partner's Name _____
First Middle Last

Address: _____

City: _____ **State** _____ **ZIP:** _____ **County:** _____

Home Phone: (____) ____ - _____ Pager/Cell #: (____) ____ - _____ Work Phone (____) ____ - _____

Marital Status: _____ **Race:** _____ **Sex:** ____ **E-Mail Address:** _____

Employer Name: _____ **Employer Phone (____) ____ - _____**

Employer Address: _____

Last Grade of Education Completed _____

Do you have a Living Will / Advanced Directives? YES □ NO □
If no, do you wish to speak to someone about a Living Will / Advanced Directives? YES □ NO □

Have you verified fertility benefits with your insurance company? YES □ NO □

Emergency Contact: _____ **Phone # (____) ____ - _____**

SPOUSE / PARTNER'S INSURANCE INFORMATION

Primary Insurance Name: _____

Address: _____
Phone #: (____) ____ - _____ Insured's Relationship to Patient: _____
Insured's Name: _____ **Insured's Date of Birth:** _____/____/_____
Policy #: _____ **Group #:** _____
Insured's Employer: _____ **Employer Phone: (____) ____ - _____**
Employer Address: _____

Secondary Insurance Name: _____
Address: _____
Phone #: (____) ____ - _____ Insured's Relationship to Patient: _____
Insured's Name: _____ **Insured's Date of Birth:** _____/____/_____
Policy #: _____ **Group #:** _____
Insured's Employer: _____ **Employer Phone: (____) ____ - _____**
Employer Address: _____

BILLING INFORMATION

Billing Name: _____
First Middle Last

Address: _____

Date of Birth: ___ / ___ / _____ **SS#:** _____ - _____ - _____ **Phone #:** (____) ____ - _____

GENERAL INFORMATION

Name of Local Pharmacy _____ **Pharmacy Phone #:** (____) ____ - _____

Which method of communication do you prefer?:
Home Phone _____ **Cell Phone** _____ **Work Phone** _____ **E-Mail** _____

Is it okay to leave a message regarding your care on your answering machine or voice mail?
HOME - Yes □ **No** □
CELL - Yes □ **No** □
WORK - Yes □ **No** □

For the privacy of our patients, information will not be discussed or released to friends, family members, co-workers, etc. unless authorized by the patients. If you authorize us to discuss or release information to someone other than the patient and the patient's spouse / partner, please indicate below.

Name: _____ **Date of Birth:** ___ / ___ / _____

Name: _____ **Date of Birth:** ___ / ___ / _____

I have been offered a copy of the Central Georgia Health Systems Notice of Privacy Practices.
Yes □ **No** □

I certify the information given to me above is correct. I hereby authorize the release of any medical or other information to any third party payers to be used by them in the consideration of payment of any claims resulting from my treatment (s). I also authorize release of said information to and from my physicians, state or federal agencies, or other health care providers if needed for such professional staff and aides it may designate to carry out such procedures, to administer treatment, and perform such care as is indicated. I consent to the performance of those medical treatments an/or procedures in addition to or different from those now contemplated that may arise from presently unforeseen conditions that may occur during my treatment. I further understand and agree that I am responsible for any balance due after insurance has been filed. A copy of this authorization my be used in place of the original.

Signature of patient: _____ **DATE:** ____ / ____ / _____

Signature of Spouse / partner: _____ **DATE:** ____ / ____ / _____