



Patient Registration Form

Today's Date: _____

Referring Source: _____

Patient's Name:		Spouse/Partner's Name:	
Date of Birth: _____	Age: _____	Date of Birth: _____	Age: _____
Social Security # _____		Social Security # _____	
Occupation: _____ Employer: _____		Occupation: _____ Employer: _____	
Home Address: _____ City/State/ Zip: _____		<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Remarried <input type="checkbox"/> Single	
Patient Contact Information:		Call Order	OK to call
Home Phone: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
Work Phone: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
Cell Phone: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
Email: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No

Responsible Party/Insurance Subscriber	Responsible Party Date of Birth: _____
Address: _____	Home Phone Number: _____
City, State, Zip: _____	Work Phone Number: _____

Primary Insurance Carrier:	Secondary Insurance Carrier:
Insurance Address: _____	Insurance Address: _____
City, State, Zip: _____	City, State, Zip: _____
Identification Number: _____	Identification Number: _____
Group Number _____	Group Number _____
Co-Pay: _____	Co-Pay: _____

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

Name: _____ **Relationship:** _____ **Telephone:** _____

I agree that the above information is correct as listed or changed as indicated. I authorize my insurance company to make payments directly to Columbia Fertility Associates, PLLC (CFA). I further authorize CFA 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.

Signature _____

Date _____