# Patient Information Form

| FIRST NAME | MIDDLE NAME | LAST NAME |
|---|---|---|
| DATE OF BIRTH | EMAIL ADDRESS | |
| SEX<br>☐ Female ☐ Male | SOCIAL SECURITY NUMBER | |
| MOBILE PHONE # | May we leave messages regarding your medical care on your voice mail?: ☐ YES ☐ NO | |

HOW WOULD YOU LIKE TO BE CONTACTED BY OUR OFFICE? (choose one or more)

☐ Text Messages ☐ Email ☐ Voice message

| STREET ADDRESS | | APARTMENT NUMBER |
|---|---|---|
| ZIP CODE | CITY | STATE |

## INSURANCE INFORMATION

| INSURANCE COMPANY NAME | INSURANCE PLAN NAME AND TYPE | RELATIONSHIP TO INSURED |
|---|---|---|
| ID NUMBER | GROUP NUMBER | EFFECTIVE DATE |
| SECONDARY INSURANCE COMPANY NAME | SECONDARY PLAN NAME AND TYPE | RELATIONSHIP TO INSURED |
| ID NUMBER | GROUP NUMBER | EFFECTIVE DATE |

## ETHNICITY

☐ Hispanic Or Latino ☐ Asian ☐ White

☐ American Indian ☐ Black or African American ☐ Pacific Islander / Native Hawaiian

☐ Decline to Specify

## SPOUSE / PARTNER INFORMATION (if applicable) (if seeking infertility treatment)

| LEGAL FIRST NAME | LEGAL LAST NAME | DATE OF BIRTH |
|---|---|---|

Please complete all information above and submit this form to IntakeForm@InfertilityDocs.com prior to coming in for your appointment.