HOW DID YOU HEAR ABOUT US?

Referring Doctor: ______________________________ **Address:** ____
Phone: ____

PATIENT DEMOGRAPHICS AND BILLING INFORMATION

Last Name:_______________________ M. Initial_____ First: ___________________________ DOB: ___ /___ /______
Address: _______________________________ City: ___________________________ State: ________ Zip:__________
Phone #'s: Home: ________________________ Work: __________________________ Cell: _____________________
Soc. Sec. #: ______________________________ Marital Status: □ M □ S □ D □ W
Ethnicity: □ American Indian/ Alaskan Native □ Asian □ Black/African American
□Hispanic/Latino □ Native Hawaiian/Pacific Islander □ White/Caucasian □ Other:________________
Employer: ____ City: ____________________________
Driver's License #: ______________________________ *(or copy license on form)*

Partner/Spouse: Last Name: ____________________________ First: __________________________ Initial: _______
DOB: ____/____/______ Phone #: (_____)______-_____________

Guarantor w/Insurance (circle): Self Partner Parent Other: _________________________________
Last Name:_______________________ M. Initial_____ First: ___________________________ DOB: ___ /___ /______
Soc.Sec.#: _______________________ Work: __________________________ Cell: _____________________
Ethnicity: □ American Indian/ Alaskan Native □ Asian □ Black/African American
□Hispanic/Latino □ Native Hawaiian/Pacific Islander □ White/Caucasian □ Other:________________
Employer: ____ City: ____________________________

Your Insurance:____ Yours________ Partners______
ID#: ___________________________________ Group #:________________________________
HAS/HRA Holders Name: _______________________________________ Effect Date:______________________
Copay $_____________ Annual Deductible $______________________ Coinsurance: ________ % _________%

Prescription drug card: _______________________________________
Secondary Insurance: ____
ID#: ___________________________________ Group #: _______________________________

Your E-mail Address: ____
_____ *I consent to medical information being transmitted via email.*

I have reviewed and signed below regarding the following statement:

I authorize the release of my medical information to process this date or any medical claims for payment to Reproductive Gynecology, Inc. or RG Labs, LLC requesting payment be made directly to their office. I understand that I am responsible for any balance on my account, including any balance over 90 days that insurance has not paid for any reason. I agree to pay office visit co-pays at the time of service and prior to any procedures. RGI does make use of a collection agency that can electronically retrieve any NSF check remitted to RGI/RGL or take collection action on any outstanding balance over 150 days overdue.

Signed:___________________________________Printed:_________________________________ Date: _______________

Granting permission with above signature to leave messages/instructions on: □ Home answering machine □ Cell answering
□ with my spouse, ______________________________ . Date: ___________________

Lab work to be submitted: ____
HOSPITAL: ____