

Nevada Fertility C.A.R.E.S.
Patient Information Questionnaire

Patient Information				
Last Name	First Name	Middle Initial		
Social Security Number	Date of Birth	Home Phone Number	Cell Phone Number	
Street Address	Apt#	City	State	Zip
Employer	Position	Work Phone Number & Extension		
Employer Address	City	State	Zip	

Spouse/Partner Information				
Last Name	First Name	Middle Initial		
Social Security Number	Date of Birth	Home Phone Number		
Street Address	Apt#	City	State	Zip
Employer	Position	Work Phone Number		
Employer Address	City	State	Zip	
IN CASE OF EMERGENCY NOTIFY:		Relationship	Phone Number	

√	Referral Source	Pharmacy Information
	Source	Name
	Friend/Relative	Name:
	Magazine Ad	Phone #
	Physician	Alternative Name:
	Provider Manual	Phone #
	Radio	
	TV	

Primary Insurance: _____ **Secondary Insurance:** _____

Referring Physician: _____ **Phone:** _____

All professional services rendered are charged to the patient. Necessary forms will be supplied to help expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance carrier payments and/or insurance coverage.

INSURANCE AUTHORIZATION & ASSIGNMENT

I hereby authorize *Nevada Fertility C.A.R.E.S.* to furnish information to insurance carriers concerning my illness and treatments, and hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

DATE: _____ **SIGNATURE:** _____