

NORTHWEST FERTILITY CENTER

•Phone (503) 227-7799 •Fax (503) 227-5452

Patient _____ Date _____
Last First Middle Name you go by

Address _____
No. & Street City State Zip Code

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate _____ Age _____ SSN # _____ Marital Status _____

Employer _____

Spouse _____
Last First Middle Name you go by

Work Phone _____ Cell Phone _____ **Birthdate** _____ Age _____

Employer _____ SSN # _____

INSURANCE CO. (Primary) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Insured's Name _____ ID# _____ Group _____

INSURANCE CO. (Secondary) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Insured's Name _____ ID# _____ Group _____

DOES YOUR INSURANCE COVER FERTILITY SERVICES? _____

How did you hear about our Center?

- Referral by Physician _____
- Friend, another patient _____
- Yellow pages _____ Internet _____

EMERGENCY CONTACT:

(Other than spouse)

Name: _____

Phone: _____

YOUR E-MAIL ADDRESS: _____

Pharmacy Name and Phone Number _____

I acknowledge that I am responsible for all charges. If it becomes necessary to involve an outside entity to collect on this account, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information to secure payment of benefits.

Signature _____ Date _____

