UNC Fertility

Today's date:	Physician Name:

PATIENT INFORMATION

Patient's Last name: First: Middle:	❑ Mr. q Mrs.	Sex: q Mq F	Marital status (circle one) Single / Mar / Div / Sep / Wid

Mailing address:	City:	State:	ZIP Code:

D.O.B: / /	Social Security No.:	Home phone no.: ( )	Cell Phone No.: ( )

Email Address:	Local Pharmacy:	Pharmacy Phone No.:

SPOUSE INFORMATION

Spouse's Last name: First: Middle:	❑ Mr. ❑ Mrs.	Social Security No.:

D.O.B: / /	Phone No.: ( )	Email Address:

REFERRAL INFORMATION

Referred by(Clinic/Doctor):

Referring Clinic/Doctor's Address:	Referring Clinic/Doctor Phone No.:

q Family q Friend q Other_____

INSURANCE INFORMATION

(**Please give your insurance card to the receptionist.)**

PRIMARY Insurance:	Group Name(Employer):	Effective Date:	Policy No.:	Group No.:

Subscriber's Name:	Subscriber's D.O.B: / /	Address (if different):	Primary Phone No.: ( )

Patient's relationship to subscriber: ❑ Self ❑Spouse ❑ Child ❑ Other

SECONDARY Insurance (*if applicable*):	Group Name(Employer):	Effective Date:	Policy No.:	Group No.:

Subscriber's Name:	Subscriber's D.O.B: / /	Address (if different):	Primary Phone No.: ( )

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize UNC Fertility or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*