

Date: _____

Patient Information Form

New Patient: Complete all sections, sign in the last block

Repeat Patient: Complete bold sections marked with an *, update any information as needed, sign in the last block

| | | | |
|--|--|--|--|
| *Patient Name (Female): _____ | | * Male Partner: _____ | |
| Address: _____ | | City: _____ State: _____ Zip: _____ | |
| *Birth Date: _____ | | *Soc. Sec. #: _____ - _____ - _____ | |
| Marital Status: Married / Single / Other | | | |
| Home Phone: (____) _____ | | Cell Phone : (____) _____ | |
| Work Phone : (____) _____ | | | |
| <i>Please circle numbers on which we can leave a detailed message: home / cell / work / none</i> | | | |
| Emergency Contact: _____ | | Phone: (____) _____ | |
| Relationship: _____ | | | |
| Employer: _____ | | Occupation: _____ | |

| | | | |
|--|--|--|--|
| <u>Primary</u> Insurance Company Name: _____ | | Phone (____) _____ | |
| Name of Insured: _____ | | Relationship to Insured: Self / Spouse / Child / Other | |
| Claims Filing Address: _____ | | | |
| Subscriber ID#: _____ | | Group #: _____ | |
| <u>Secondary</u> Insurance Company Name: _____ | | Phone (____) _____ | |
| Name of Insured: _____ | | Relationship to Insured: Self / Spouse / Child / Other | |
| Claims Filing Address: _____ | | | |
| Subscriber ID#: _____ | | Group #: _____ | |
| <i>If Insured on Primary or Secondary Policy is Other than Patient:</i> | | | |
| Insured's Birth Date: _____ | | Insured's Soc. Sec. #: _____ - _____ - _____ | |
| Insured's Home Phone: (____) _____ | | Insured's Work Phone: (____) _____ | |
| Insured's Employer or Occupation: _____ | | Plan or Program Name: _____ | |
| <input type="checkbox"/> *File a courtesy claim with my insurance carrier(s) (information as provided above). I understand that I am responsible to obtain any necessary referrals or authorization for treatment. I understand that Virginia IVF & Andrology Center is non-participating with all insurance plans and that I am responsible to pay all charges at the time of service, unless otherwise directed by Virginia IVF & Andrology Center. | | | |
| <input type="checkbox"/> *Do not file a courtesy claim with my insurance carrier. | | | |

| | |
|--|---------------------|
| I understand that Virginia IVF & Andrology Center is a Virginia limited liability company owned and operated by the following individuals: Drs. Edelstein, Gianfortoni, Matt, Rosenberg, Steingold and Tidey. Dr. Matt is the Laboratory Director for Virginia IVF & Andrology Center. All other owners are physicians who provide treatment and procedures at the laboratory as an extension of their office practices. Other physicians may, on occasion, also perform procedures at the laboratory. | |
| I hereby authorize Virginia IVF & Andrology Center to release information regarding services rendered to me to the insurance company(ies) named heron; and assign payment directly to Virginia IVF & Andrology Center. I understand that I am financially responsible for all charges incurred by me at Virginia IVF & Andrology Center. I agree that in the event that my account must be referred to an attorney for collection, I will be responsible for all attorney's fees, court costs, and interest. | |
| *Signature: _____ | *Date: _____ |

PHYSICIAN / VIRGINIA IVF & ANDROLOGY CENTER USE ONLY

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|---|--------------------------------|
| Treating Physician: _____ Michael Edelstein, M.D. | _____ Joseph Gianfortoni, M.D. |
| _____ Sanford Rosenberg, M.D. | _____ Kenneth Steingold, M.D. |
| _____ Geof Tidey, M.D. | _____ Elizabeth McGee, M.D. |
| _____ Other _____ | |