PATIENT REGISTRATION FORM

How did you hear about us?	**Today's date:**
Name *(Last, First, M.I.):*	
DOB:	**SSN:**
Primary reason for consultation: ☐ Fertility ☐ Pain ☐ Others (please specify)	
Address:	**Email:**
	Phone:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Occupation:	**Employer:**

Spouse / Significant others information	
Name *(Last, First, M.I.):*	
Phone:	**Relationship:**
Occupation:	**Employer:**
Is this person your emergency contact as well? ☐ Yes ☐ No (If No, please provide name, phone number and relationship of emergency contact below)	

Insurance Information: ***I certify that, I, and / or my dependents (s) have insurance coverage with:***	
Insurance Carrier: ☐ PPO ☐ POS ☐ HSA ☐ HMO ☐ Other:	
ID #:	**Group #:**
Claims Address:	**Insurance Phone:**
Name of primary subscriber *(Last, First, M.I.):*	
DOB:	**SSN:** / **Relationship:**

Financial Responsibility: ***Who is financially responsible for all charges whether or not paid by insurance:***		
Name *(Last, First, M.I.):*		
DOB:	**SSN:**	**Relationship:**

I certify that the above information is correct and that the Center for Restorative Reproductive Surgery (CRRS) has your permission to speak to the above named individuals in cases of emergency. I authorize the use of my signature on all insurance submissions. I assign directly to CRRS all insurance benefits, if any, otherwise payable to me for services rendered. CRRS may use my heath care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that CRRS will submit claims to my Primary Insurance Carrier only; I will be responsible for submitting to a Secondary Insurance Carrier, if applicable.

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Printed Name **Signature**