University Reproductive Associates, P.C.
Patient Registration

Patient Information

Name_____ Date of Birth _____Age_____
(Last) (First) (MI)

Address_____ Home Phone (_____)_____

City _____ State _____ Zip _____ Cell Phone (_____)_____

Social Security # _____ Drivers License # _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Partner/Spouse Name _____ Date of Birth _____

Partner/Spouse Social Security # _____

Referring Physician _____

Emergency Contact _____ Phone (_____)_____

Relationship to patient ☐ Spouse ☐ Parent ☐ Other _____

Employment Information:
Patient:
Employer_____ Phone (_____)_____

Address _____

City_____ State _____ Zip Code _____

Employed: ☐ Full Time ☐ Part Time ☐ Seasonal

Insurance Information:

Primary:

Insurance Carrier _____ Co-pay Amount _____

Policy Number _____ Group Number_____

Guarantor: ☐ Self ☐ Other-Name _____

If other than self:
Social Security # _____ Date of Birth_____

Prescription Information:

Prescription Carrier _____ Co-pay Amount _____

Policy Number _____ Group Number _____

Secondary Insurance:

Insurance Carrier _____ Co-pay Amount _____

Policy Number _____ Group Number_____

Guarantor: ☐ Self ☐ Other-Name _____

If other than self:
Social Security # _____ Date of Birth_____

Please Note: All patients are responsible for annual deductibles, co-pays and/or any co-insurance amounts as assigned by your insurance carrier. All self-pay patients are required to pay for services on the date rendered.

I hereby authorize my insurance benefits to be paid directly to University Reproductive Associates, P.C. for all services rendered. I also authorize the release of any medical information to my insurance carrier concerning my Illness. I understand that l am financially responsible for any fees, deductibles, co-payments and any non-covered services that may apply as directed by my insurance plan.

Patient/Guarantor _____Date_____