Columbia Fertility Associates

Today's Date: _____ **Patient Registration Form** **Provider Scheduled With**:_____

Patient's Legal Name: _____ **Last** **First** **MI** **Name you wish to be called:** **Pronoun used:** ❑She/her ❑He/him ❑They/them ❑_____	**Date of Birth:** _____ **Age**:_____ **SS#:** _____ **Home Address:** _____ **Apt/Unit #:** _____ **City/State/Zip:** _____
Sex (assigned at birth): ❑Female ❑Male ❑Intersex **Words Describing Your Gender (select all that apply):** ❑Female ❑Male ❑Nonbinary ❑Cisgender ❑Transgender ❑Agender ❑_____ ❑Single ❑Married ❑Partnered (Unmarried) ❑ Divorced ❑Widowed ❑Separated	**Occupation:** _____ **Employer:** _____ **Language**: _____ **Race**: _____ **Ethnicity**: _____ **Sexual Orientation**: ❑Queer ❑Lesbian ❑Bisexual ❑Gay ❑Heterosexual ❑Pansexual ❑_____

Patient Contact Information	**Call Order**	**OK to Contact**	**OK to Leave Detailed Message**
Cell Phone:		❑Yes ❑No	❑Yes ❑No
Work Phone:		❑Yes ❑No	❑Yes ❑No
Home Phone:		❑Yes ❑No	❑Yes ❑No
Email Address:			**OK to email medical results**: ❑Yes ❑No

Spouse/Partner's Name: _____ **Name they wish to be called:** _____ **Pronoun used:** ❑She/her ❑He/him ❑They/them ❑_____	**Date of Birth**: _____ **Age**: _____**SS#:** _____ **Occupation**: _____ **Employer**: _____
Sex (assigned at birth): ❑Female ❑Male ❑Intersex **Words Describing Their Gender:** ❑Female ❑Male ❑Nonbinary ❑Cisgender ❑Transgender ❑Agender ❑_____	**Cell phone**: _____ **Work phone**: _____

Emergency Contact Information	**Preferred Pharmacy Name**:
Name: **Relationship**:	**Phone**: **FAX:**
Phone:	**Address:**

Primary Insurance Carrier:	**Secondary Insurance Carrier:**
Insurance Address:	Insurance Address:
Insurance Address:	Insurance Address:
Subscriber Name: DOB	**Subscriber Name: DOB**
Relationship to the subscriber: ❑Self ❑Spouse ❑Partner ❑ Child	Relationship to the subscriber: ❑Self ❑Spouse ❑Partner ❑ Child
Identification Number:	Identification Number:
Group Number:	Group Number:
Specialist Co-Pay: $	Specialist Co-Pay: $

WHO DO WE THANK FOR REFERRING YOU? (Please check all that apply)

❑Provider* ❑Patient _____ ❑Friend/Relative ❑Social Media_____ ❑Internet/Web Site ❑Radio_____ ❑Washingtonian Top Doctors ❑Other_____	***Referring Provider Name**: _____ Specialty: _____ Address:_____ City/State/Zip:_____ Phone:_____ FAX: _____

I agree that the above information is correct as listed or changed as indicated. I authorize my insurance company to make payments directly to Columbia Fertility Associates, PLLC (CFA). I further authorize CFA to release any information about my medical care to my insurance company. This includes diagnosis, treatment and other information contained within the medical record. I agree to pay for any medical services that are not covered under my insurance, This includes all co-pays and co-insurance balance.

_____ _____

Patient/Guardian Signature **Date**

For Office Use Only

Account updated by: _____(Initials) Date:_____ Form Revised 05/25/2025 smo