MID-IOWA FERTILITY
Extraordinary care. Extraordinary results.

PATIENT INFORMATION

Please complete form using dark blue or black ink only

NAME (Last, First, Middle) SSN# BIRTHDATE M F MAIDEN NAME

ADDRESS CITY STATE/ZIP

EMAIL ADRESS HOME PHONE CELL PHONE

EMPLOYER ADDRESS OCCUPATION

EMPLOYER PHONE REFERRED BY

SPOUSE/NEXT OF KIN INFORMATION

NAME (Last, First, Middle) SSN# BIRTHDATE M F RELATIONSHIP TO PATIENT

ADDRESS DAYTIME PHONE

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY POLICY NUMBER GROUP NUMBER

NAME OF INSURED INSURED BIRTHDATE

CLAIMS MAILING ADDRESS

CUSTOMER SERVICE NUMBER COPAY $

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY POLICY NUMBER GROUP NUMBER

NAME OF INSURED INSURED BIRTHDATE

CLAIMS MAILING ADDRESS

CUSTOMER SERVICE NUMBER COPAY $

By signing below, I acknowledge that I have been informed of Mid-Iowa Fertility's Privacy Policy and the Document Control Policy. A copy of the policy is available upon my request. I understand that all information will be securely maintained on the server(s) at Mid-Iowa Fertility, and will only be released as set forth in the Privacy Policy and by my written instruction.

I authorize Mid-Iowa Fertility, P.C. to release my PHI (Protected Health Information) to the insurance carrier(s) I have provided in order to facilitate claim payment. I permit a copy of this authorization with my signature to be used in place of the original and request that payment for claims are paid directly to Mid-Iowa Fertility, P.C. I understand I am responsible for all services received regardless of insurance payment or denial.

I further acknowledge that it is my responsibility to notify Mid-Iowa Fertility of any changes to my personal information such as address, phone number, insurance coverage, etc.

Patient Signature Date