Fertility Specialists of Texas
Patient Profile

Patient Information

Name: ______________________________
Address: ______________________________
City: ______________State: _____Zip:_________
Home Phone: ______________________________
Cell Phone: ______________________________
Email Address: ______________________________
DOB: ______________________________
Drivers License #: _______________State: ______
SSN: ______________________________
Marital Status: ______________________________
Employer Name: ______________________________
Occupation: ______________________________
Work Phone: ______________________________

Primary Insurance

INS Company: ______________________________
Member ID #: ______________________________
Group #: ______________________________
Phone #: ______________________________
Cardholder: ______________________________

Secondary Insurance

INS Company: ______________________________
Member ID #: ______________________________
Group #: ______________________________
Phone #: ______________________________
Cardholder: ______________________________

Spouse/Partner Information

Name: ______________________________
DOB: ______________________________
SSN: ______________________________
Phone: ______________________________
Ins Company: ______________________________
Member ID #: ______________________________
Group #: ______________________________
Phone #: ______________________________
Cardholder: ______________________________
Employer: ______________________________
Occupation: ______________________________
Work Phone: ______________________________

Emergency Contact

Name: ______________________________
Relationship: ______________________________
Phone: ______________________________

Pharmacy Information

Name: ______________________________
Phone: ______________________________
Address: ______________________________
City: ___________________ State: ______________
Drug Allergies: ______________________________

I hereby assign payment of medical benefits to Fertility Specialists of Texas/formerly Fertility Specialists of Dallas for all services rendered. I understand that I am financially responsible for all charges, whether or not paid by the above said insurance company's and that payment in full must be paid within thirty days of statement billing and that Fertility Specialists of Texas/formerly Fertility Specialists of Dallas may send any records necessary to secure payment from the insurance company. Any balances over 90 day old will be turned over to a collection agency and additional fees will accrue. All information provided is true and correct and a copy of this signed document is as valid as the original.

Patient Signature: ______________________________ Date: ______________________________

Please list people with whom we can discuss your care and leave messages:
1) ______________________________ Phone: ______________________________
2) ______________________________ Phone: ______________________________

May we call/leave messages on your answering machine on your: ***Home:*** Y / N ***Work:*** Y / N ***Cell:*** Y/ N (Please understand that if we cannot leave messages, it will be **your** responsibility to initiate contact us regarding of your care.)
I have received information regarding the Notice of Privacy Practices from Fertility Specialists of Texas/formerly Fertility Specialists of Dallas.
{ } I want a copy. { } I do not want a copy. Patient Signature: ______________________________