UNIVERSITY OF PITTSBURGH PHYSICIANS
CENTER FOR FERTILITY AND REPRODUCTIVE ENDOCRINOLOGY

Patient's Name:

Date of Birth: | **Social Security #:**

Marital Status: Single Married Divorced | **Sex:** Female Male

Address:

City: **State:** **Zip Code:**

Home Phone #: **Work Phone #:** **Cell #:**

PCP (Family Doctor): **PCP Phone #:**

Physician Referring to Our Practice (or Self, etc.):

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Patient's Employer: **(Full Time / Part Time,etc)**

Occupation:

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Emergency Contact # 1: | **Relationship:**

Home Phone #: **Work Phone #:** **Cell #:**

Emergency Contact # 2: | **Relationship:**

Home Phone #: **Work Phone #:** **Cell #:**

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The Adult - Financially Responsible - For The Patient - - - IF the patient is not of age

Name: | **Relationship:**

Address:

City: **State:** **Zip Code:**

Social Security #: **Date of Birth:**

Home Phone #: **Work Phone #:** **Cell #:**

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Primary Insurance:	**Employer:**	
Subscriber's Name:	**Occupation:**	
Insurance Name:	**Effective Date:**	
Insurance/Subscriber ID #:	**Group #:**	
Social Security #:	**Date of Birth:**	
Relationship to Patient:	**Sex: F M**	**Copays:**

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Secondary Insurance:	**Employer:**	
Subscriber's Name:	**Occupation:**	
Insurance Name:	**Effective Date:**	
Insurance/Subscriber ID #:	**Group #:**	
Social Security #:	**Date of Birth:**	
Relationship to Patient:	**Sex: F M**	**Copays:**

PATIENT's - Registration Form

UNIVERSITY OF PITTSBURGH PHYSICIANS
CENTER FOR FERTILITY AND REPRODUCTIVE ENDOCRINOLOGY

Partner's Name:

Date of Birth: | **Social Security #:**

Marital Status: Single Married Divorced | **Sex:** Female Male

Address:

City: **State:** **Zip Code:**

Home Phone #: **Work Phone #:** **Cell #:**

PCP (Family Doctor): **PCP Phone #:**

Physician Referring to Our Practice (or Self, etc.):

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Partner's Employer: **(Full Time / Part Time / Not Employed,etc)**

Occupation:

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Emergency Contact # 1: | **Relationship:**

Home Phone #: **Work Phone #:** **Cell #:**

Emergency Contact # 2: | **Relationship:**

Home Phone #: **Work Phone #:** **Cell #:**

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The Adult - Financially Responsible - For The Patient - - - IF the patient is not of age

Name: | **Relationship:**

Address:

City: **State:** **Zip Code:**

Social Security #: **Date of Birth:**

Home Phone #: **Work Phone #:** **Cell #:**

>>

Primary Insurance:	**Employer:**	
Subscriber's Name:	**Occupation:**	
Insurance Name:	**Effective Date:**	
Insurance/Subscriber ID #:	**Group #:**	
Social Security #:	**Date of Birth:**	
Relationship to Patient:	**Sex: F M**	**Copays:**

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Secondary Insurance:	**Employer:**	
Subscriber's Name:	**Occupation:**	
Insurance Name:	**Effective Date:**	
Insurance/Subscriber ID #:	**Group #:**	
Social Security #:	**Date of Birth:**	
Relationship to Patient:	**Sex: F M**	**Copays:**

PARTNER's - Registration Form

Please Read and Sign Below

Direct Payment Request and Authorization to Release Medical Information

I hereby authorize the release of information aquired during the course of my examination and treatment to the Health Care Financing Administration and it's agents or any other third party carrier as necessary to secure payment of any benefits due to me. I hereby assign payments of said benefits to include Medicare benefits directly to my physician. I understand that I am responsible for all charges regardless of insurance status as well as any associated costs for collection should such action become necessary. I agree that this authorization shall be valid until canceled in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

Patient Signature **Date**

Responsible Party **Date**