OREGON HEALTH & SCIENCE UNIVERSITY

FERTILITY CONSULTANTS
ANDROLOGY/EMBRYOLOGY LABORATORY
Center for Health & Healing
3303 SW Bond Avenue, 10th Floor
Portland, OR 97239-4501

PATIENT NAME: _____
(First) (Middle) (Last)

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SEX: ☐ Female ☐ Male EMPLOYER: _____

PHONE (+ Area Code) - HOME: _____ WORK & EXT.: _____

DATE OF BIRTH: _____ SOCIAL SECURITY № _____

PATIENT OHSU MEDICAL RECORD № _____ MARITAL STATUS: _____

SPOUSE'S NAME: _____

WHICH DOCTOR ARE YOU SEEING TODAY? ☐ **Amato** ☐ **Gorrill** ☐ **Lee** ☐ **Patton**

REFERRING PHYSICIAN/CLINIC NAME & ADDRESS: (Necessary for us to communicate with your physician)

Would you like us to bill your insurance?

☐ **Yes** If "Yes", complete "**INSURANCE INFORMATION**" below. If you have 2 or more insurance plans, please request additional forms. **We need to make a copy of your insurance card today.**

☐ **No** If "No", the Patient will be responsible for the account.

► **INSURANCE INFORMATION** ◄ DOES YOUR INSURANCE HAVE INFERTILITY BENEFITS? ☐ Yes ☐ No

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S SEX: ☐ Male ☐ Female

SUBSCRIBER'S EMPLOYER: _____ WORK PHONE (+ Area Code): _____

SUBSCRIBER'S DATE OF BIRTH: _____ SUBSCRIBER'S SOCIAL SECURITY № _____

INSURANCE CO.: _____ PHONE (+ Area Code): _____

GROUP NAME & I.D. NUMBER: _____

AGREEMENT

I authorize release of my medical records necessary to process claims and payment of medical benefits to the physician and suppliers. I acknowledge that I am responsible for all charges whether or not they are covered by insurance. If I am a member of a managed care network, and have not obtained a referral or have an authorization in place for my appointment, I understand that I am responsible for all charges incurred. I may be asked to pay for today's charges even if coordination of benefits is to be done. I understand that claims submitted to insurance will include a diagnosis reflecting the topics covered during the visit. Multiple diagnoses may be used.

SIGNATURE: _____ DATE: _____