HRC Fertility

PATIENT REGISTRATION FORM

15503 Ventura Blvd., Ste 200
Encino, CA 91436
(818) 788-7288

1950 Sunnycrest Dr., Ste 2400
Fullerton, CA 92835
(714) 738-4200

23961 Calle de la Magdalena, Ste 503
Laguna Hills, CA 92653
(949) 472-9446

500 Superior Ave., Ste 210
Newport Beach, CA 92663
(949) 287-5600

3231 Waring Ct., Ste M
Oceanside, CA 92056
(760) 758-2034

333 S. Arroyo Pkwy., 3rd Floor
Pasadena, CA 91105
(626) 440-9161

1220 La Venta Dr., Ste 103
Westlake Village, CA 91361
(805) 374-1737

11500 W. Olympic Blvd., Ste 504
West Los Angeles, CA 90064
(310) 481-0881

PATIENT'S ACCOUNT	ASSIGNED PHYSICIAN	CATEGORY

NAME (FIRST INIT., LAST)	**HOME PHONE NO.**	**DOB**	**AGE**

ADDRESS	CITY, STATE, ZIP CODE

SOCIAL SECURITY NO.	DL#	SEX (M/F)	MARITAL STATUS	ETHNICITY

OCCUPATION	EMPLOYER	EMAIL ADDRESS

WORK ADDRESS	CITY	STATE	ZIP CODE

WORK PHONE NO. ( ) -	REFERRAL	IN CASE OF EMERGENCY CONTACT PERSON AND PHONE NO.

PREFERRED MSG NO.	CELL PHONE NO.	PAGER NO. ( ) -	FAX NO.

PRIMARY INSURANCE INFO. PLEASE PROVIDE COPY OF INSURANCE CARD	INSURANCE NAME & ADDRESS

SUBSCRIBER NO.	GROUP NO.	COVERAGE FROM	COVERAGE TO

INSURANCE PHONE NUMBER	INSURED'S NAME	INSURED'S DATE OF BIRTH

SECONDARY INSURANCE INFO. PLEASE PROVIDE COPY OF INSURANCE CARD	INSURANCE NAME & ADDRESS

SUBSCRIBER NO.	GROUP NO.	COVERAGE FROM	COVERAGE TO

INSURANCE PHONE NUMBER	INSURED'S NAME	INSURED'S DATE OF BIRTH

PARTNER'S NAME (FIRST INIT., LAST)	**ACCT.**	**HOME PHONE NO.**	**DOB**	**AGE**

ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY NO.	DL#	SEX (M/F)	MARITAL STATUS	ETHNICITY

OCCUPATION	EMPLOYER	EMAIL ADDRESS

PARTNER'S WORK ADDRESS	CITY	STATE CA	ZIP CODE

WORK PHONE NO. ( ) -	REFERRAL	IN CASE OF EMERGENCY CONTACT PERSON AND PHONE NO.

PREFERRED MSG NO.	CELL PHONE NO.	PAGER NO. ( ) -	FAX NO.

I/We authorize payment of medical benefits be made directly to the physician provider for services rendered. I/We authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information to this claim and the expenses reported. I/We understand and agree that (regardless of any insurance status) I am/we are ultimately responsible for any balance on my/our account(s) and for any services rendered.

By becoming a patient at HRC, I/we give our consent to be evaluated and treated for reproductive endocrine and infertility issues. I/we understand that routine medical care, such as annual exams and pap smears, will be performed by my PCP or OB/GYN.

Signed (Insured or Authorized)	Signed (Partner)	Date

Signed (Insured or Authorized)	Signed (Partner)	Date