Patient Information

Gender ☐ Female ☐ Male

Name ____ Date of Birth _____ /_____ /_____
First Middle Last

Address ____
Street City State ZIP

Phone # ___________________________ ___________________________ ______________________________
Mobile Home Work

Email Address _______________________________________ ☐ decline to provide

Marital Status: ______________________________ Maiden Name (if applicable): ________________________________

Occupation: _____________________________ Military: ☐ Active ☐ Retired Employer: _________________________

Employer Address: ____
Street City State ZIP

Social Security # ________ -________ - ________ Driver's License # _________________________ State _______

Partner Information ☐ N/A

Gender ☐ Female ☐ Male

Name: ____ Date of Birth: _____ /_____ /_____
First Middle Last

☐ Address same as above

Address ____
Street City State ZIP

Phone # ___________________________ ___________________________ ______________________________
Mobile Home Work

Email Address _______________________________________ ☐ decline to provide

Occupation _____________________________ Military ☐ Active ☐ Retired Employer _________________________

Employer Address: ____
Street City State ZIP

Social Security # ________ -________ - ________ Driver's License # _________________________ State _______

Emergency Contact Information

Name: ____ Relationship: ____________________
First Middle Last

Address: ____
Street City State ZIP

Phone # ________________________ ________________________ ___________________________
Mobile Home Work

Email Address ___________________________________ □ decline to provide

Contact Preferences

Please denote the primary number where you wish to be contacted and where we are authorized to leave sensitive medical information, such as medication instructions, appointment times and lab results. Email may be used to communicate with our support teams (Nursing, Financial) and to share upcoming events and information.

Patient □ Mobile □ Home □ Work **Partner (if applicable)** □ Mobile □ Home □ Work

Legal Status with Respect to Partner and Patient □ N/A

- We state our agreement and intent that we shall conclusively be presumed to be the sole legal parents of any fetuses and/or child(ren) resulting from treatment.
- As the legal parent(s), we agree to assume all parental, custodial, and testamentary rights and obligations with respect to such embryo(s), fetuses and/or child(ren).
- We understand, however, that in the event that we are not legally married, the legal status of the patient's partner as co-parent of such child(ren) is as yet uncertain.
- We acknowledge that we have had an opportunity to consult with an attorney, if we so desire.

Disclosure to Partner □ N/A

By signing below I certify that all information pertaining to me or my partner may be shared with both/either of us by the staff at Fertility Specialists Medical Group, Inc.

Patient Signature ____ Date _____ /_____ /_____

Partner Signature ____ Date _____ /_____ /_____