

Mid-Iowa Fertility, P.C.

PATIENT INFORMATION

***Please complete form using blue or black ink only.*

NAME (Last, First, Middle)	SSN#	BIRTHDATE	M F	MAIDEN NAME
ADDRESS		CITY		STATE/ZIP
EMAIL ADDRESS	HOME PHONE			CELL PHONE
EMPLOYER	ADDRESS			OCCUPATION
EMPLOYER PHONE				REFERRED BY

SPOUSE/NEXT OF KIN INFORMATION

NAME (Last, First, Middle)	SSN#	BIRTHDATE	M F	RELATIONSHIP TO PATIENT
ADDRESS				DAYTIME PHONE

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER
NAME OF INSURED	INSURED BIRTHDATE	
CLAIMS MAILING ADDRESS		
CUSTOMER SERVICE NUMBER	COPAY \$	

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER
NAME OF INSURED	INSURED BIRTHDATE	
CLAIMS MAILING ADDRESS		
CUSTOMER SERVICE NUMBER		

By signing below, I acknowledge that I have read, and received a copy if desired, Mid-Iowa Fertility's Privacy Policy and the Document Control Policy. Specifically I understand that all paper forms will be scanned and maintained electronically. All information will be securely maintained on the server(s) at Mid-Iowa Fertility, and will only be released as set forth in the Privacy Policy and by my written instruction.

Patient Signature

Date