Valley Center for Reproductive Health

Patient Name	SS#	Date of Birth	Cell Phone
Partner name	DOB	M / S / D /W / sep	Cell phone
Address	Apt	City, State, Zip	Home phone
Occupation	Employer	Business phone	FAX
Work address	City, State, Zip		Bus FAX
Drivers License	Email	Pharmacy	Pharmacy phone
In case of emergency notify	Phone	relationship	
Insurance; name of insured	Insurance co	Policy #	Group #
Insurance address	City, State, Zip	HMO: Y/ N	HMO medical group
Partner's Occupation	Partner Employer		Bus phone
Partners work address		Partners email	
Referring Physician	Phone		
Primary care physician	Phone		
Referred by:			

Authorization of Treatment Assignment of Benefits, Release of Medical Information, Financial Responsibility
I understand that I am financially responsible for charges incurred at the time of service or for any charges not covered by an approved contractual provider insurance or insured benefits. I am also responsible for any collection fees or legal costs incurred should costs be necessary because of non-payment. I hereby authorize the release of any medical records or other information necessary for the processing of insurance benefits of medical and/or surgical services rendered.

I hereby authorize payment of benefits directly to VALLEY CENTER FOR REPRODUCTIVE HEALTH, INC. for procedural, surgical and /or medical benefits, if any, otherwise payable to me for their service.
HMO patients should be aware that you are financially responsible for all unauthorized services.
I hereby authorize treatment by Valley Center for Reproductive Center Health, Inc.

Signature of Patient: _____ Date:_____

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