

Advanced Reproductive Medicine and Surgery, P.C.
4190 Telegraph Rd. Suite 1500 Bloomfield Hills, MI 48302
Phone (248) 203-0900 Fax (248) 203-0902

PATIENT INFORMATION

Name _____		Mid. Int. _____	
Marital Status _____	Age _____	Birth Date _____	Home Phone _____
Business Phone _____	Cellular Phone _____	*E-mail _____	
<small>*Disclosure: Information sent to you may not be secure.</small>			
Is it okay to leave a message at: Home <input type="checkbox"/> Yes <input type="checkbox"/> No Business <input type="checkbox"/> Yes <input type="checkbox"/> No Cellular <input type="checkbox"/> Yes <input type="checkbox"/> No Email <input type="checkbox"/> Yes <input type="checkbox"/> No			
I authorize my partner to receive my medical information. <input type="checkbox"/> Yes <input type="checkbox"/> No _____			Signature _____
Address _____	City _____	State _____	Zip _____
Employed By _____	Position _____		
Address _____	Social Security Number _____		

PARTNER INFORMATION

Partner's Name _____	Birth Date _____
I authorize my partner to receive my medical information. <input type="checkbox"/> Yes <input type="checkbox"/> No _____	
Signature _____	
Employed By _____	Position _____
Address _____	
Business Phone _____	Okay to call Business <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number _____	

REFERRAL INFORMATION

Referred By _____
Physician's Address _____
Copy of records from referring physician <input type="checkbox"/> Yes <input type="checkbox"/> No Do you want a follow up note sent to your referring physician? <input type="checkbox"/> Yes <input type="checkbox"/> No

INSURANCE INFORMATION

Primary Insurance _____	
Subscriber _____	
Insurance Numbers _____	

I authorize Advanced Reproductive Medicine and Surgery, P.C. to file claim(s) on my behalf to my insurance.	
_____	_____
Patient Name	Date