

**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 \_\_\_\_\_  
\*Disclosure: Information sent to you may not be secure.  
Is it okay to leave a message at: Home  Yes  No Business  Yes  No Cellular  Yes  No Email  Yes  No  
I authorize my partner to receive my medical information.  Yes  No \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Employed By \_\_\_\_\_ Position \_\_\_\_\_  
Social Security Number \_\_\_\_\_

**PARTNER INFORMATION**

Partner's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
I authorize my partner to receive my medical information.  Yes  No \_\_\_\_\_  
Signature \_\_\_\_\_  
Home Address (if different from Patient) \_\_\_\_\_  
Employed By \_\_\_\_\_ Position \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Cellular Phone \_\_\_\_\_  
Business Phone \_\_\_\_\_ Okay to leave message at: Business  Yes  No Cellular  Yes  No

**REFERRAL INFORMATION**

Referred By \_\_\_\_\_  
Physician's Address \_\_\_\_\_  
Copy of records from referring physician  Yes  No Do you want a follow up note sent to your referring physician?  Yes  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 \_\_\_\_\_