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Patient's Name: Last, First, Middle Initial		S.S.#		Marital Status M / S / D / W / Sep		Birth Date	
Street Address			City, State, Zip			Home Phone (preferred) <input type="checkbox"/>	
Patient's Employer		Occupation		Business Phone		Cell Phone (preferred) <input type="checkbox"/>	
Employer's Address			City, State, Zip		Personal Fax		
Drug Allergies, If Any		Are you Diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No		Drivers License #		Email Address	
Spouse/Partner's Name: Last, First, Middle Initial			S.S.#		Birth Date		
Address (If different)			City, State, Zip		Home Phone		
Spouse / Partner's Employer			Occupation		Business Phone		
Employers Address			City, State, Zip		Cell Phone		
In Case of Emergency, Notify			Relationship		Phone		
Name of Person Insured		Effective Date		Certificate / Policy #		Group #	
Name of Insurance Company				HMO Yes / No		Subscriber #	
Insurance Address			City, State, Zip				
How did you learn about SCRC? Please Check all that apply							
<input type="checkbox"/> Friend		<input type="checkbox"/> Mailer		<input type="checkbox"/> Advertisement		<input type="checkbox"/> Website	
Name:							
<input type="checkbox"/> Seminar		<input type="checkbox"/> Radio		<input type="checkbox"/> TV		Referring Physician	
Date:		Station:		Station:		Physician Phone	
SCRC is committed to safeguarding your confidentiality. We are also committed to educating the community on issues concerning infertility. May we inform you of future SCRC educational events? <input type="checkbox"/> YES <input type="checkbox"/> NO				Occasionally, media and press outlets interview SCRC physicians and request to speak with patients. Do you consent to have <u>SCRC contact you</u> if such a media request is made? <input type="checkbox"/> YES <input type="checkbox"/> NO			
<p>AUTHORIZATION OF TREATMENT ASSIGNMENT OF BENEFITS, REALEASE OF MEDICAL INFORMATION FINACIAL RESPONSIBILITY</p> <p>I understand that I am financially responsible of 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 cost 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.</p> <p>I hereby authorize payment of benefits directly to <u>Southern California Reproductive Center</u> for the procedural, surgical, and/or medical benefits if any, otherwise payable to me for their service.</p> <p>HMO patients should be aware that you are financially responsible for all the unauthorized services.</p> <p>I hereby authorize treatment by <u>Southern California Reproductive Center</u>.</p>							
Signature of Patient, Guarantor, or Guardian						Date	