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44105 N.15th Street, West
Lancaster, CA 93534
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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) ☐	
Patient's Employer	Occupation	Business Phone	Cell Phone (preferred) ☐
Employer's Address	City, State, Zip	Personal Fax	
Drug Allergies, If Any	Are you Diabetic? ☐ Yes ☐ 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	Alternate 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

☐ Friend Name:	☐ Mailer	☐ Advertisement	☐ Website
☐ Seminar Date:	☐ Radio Station:	☐ TV Station:	Referring Physician	Physician Phone

SCRC is committed to safeguarding your confidentiality. We are also committed to educating the community on issues concerning infertility. May we include you on future SCRC mailings?

☐ YES ☐ NO

<u>AUTHORIZATION OF TREATMENT ASSIGNMENT OF BENEFITS, REALEASE OF MEDICAL INFORMATION FINACIAL RESPONSIBILITY</u>

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.

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.

HMO patients should be aware that you are financially responsible for all the unauthorized services.

I hereby authorize treatment by <u>Southern California Reproductive Center.</u>

Signature of Patient, Guarantor, or Guardian Date