

RUTEK Center for Reproductive Medicine, P.A.

New Patient Registration Form

PATIENT INFORMATION

Today's Date ___/___/___ Patient's Name _____

SS# _____ Driver's License No. _____ Marital Status _____

Address _____
Number Street apt. # city state zip code

Home Phone # (____) _____ Date of Birth ___/___/___ Age ____ Sex _____

Cell Phone # (____) _____ Patient's Email _____

Employer Name _____ Street Address _____

City _____ State _____ Zip _____ Business Phone No. _____

SPOUSE'S INFORMATION

Full Legal Name _____ DOB _____ SS# _____

Address (If Different From Above) _____

Cell Phone No. _____ Email _____ Home Phone No. _____

Employer Name _____ Street Address _____

City _____ State _____ Zip _____ Business Phone No. _____

INSURANCE INFORMATION

PRIMARY INSURANCE Company Name _____

ID# _____ Group# _____ Phone No. _____

Subscriber Name _____ Where to send claim _____

SECONDARY INSURANCE Company Name _____

ID# _____ Group# _____

OTHER INSURANCE INFORMATION _____

EMERGENCY INFORMATION

Person to Notify in Case of Emergency _____ Relationship _____

Address _____

City _____ State _____ Zip _____ Phone No. _____

INFORMATION FOR THE PATIENT

1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc.
2. Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc) require a copayment at the time of service. Most contract health plans require that the claim be submitted by our office.
3. If you have any questions we will, of course, be happy to assist you.

I hereby authorize Dr. Willie D. Zoma to release any and all information necessary for filing claims for services I received to the insurance companies listed above. I hereby authorize the insurance companies listed above to make payment of benefits directly to Dr. Willie D. Zoma for services rendered by them. I also hereby acknowledge I am financially responsible for all charges not paid by insurance. This agreement will remain in effect until revoked by me in writing. Photocopy of the assignment is to be considered as valid as an original.

In event that this account becomes past due, I understand that it is subject to a 1.5% per month finance charge. Also, I understand that if the account becomes 60 days past due it will be turned over for collection and I agree to pay an additional 25% collection fee based on the total amount due.

PATIENT'S SIGNATURE _____ **Date** _____

PATIENT'S FULL NAME (Please print) _____