NEW PATIENT REGISTRATION SHEET

Endocrine Infertility Today's Date _____

Who referred you to our clinic? _____

What is the name of your Family physician _____

Have you ever had ANY type of fertility work up or treatment? YES NO
If so list the Name of the physician and the number of treatment cycles: _____

_____

PERSONAL DATA

Marital Status? ☐Married ☐Single ☐Domestic Partner

Student: ☐Full-time ☐Part-time ☐Not in school

Are you a Veteran? YES NO

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐ Refused/Unreported

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black or African American ☐Caucasian/White ☐Native Hawaiian ☐Other Pacific Islander ☐ Refused/Unreported

Name _____ DOB_____ SSN # _____

Partner _____ DOB_____ SSN # _____

Address _____

_____

Home phone _____
Cell phone _____
Patient Work phone _____
Partner Work phone _____

Patient Employer: _____
Partner Employer: _____

Patient Insurance Company _____
Partner Insurance Company _____

Preferred Pharmacy: _____
Address and Phone _____

2 Emergency Contacts Name/Phone _____

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