

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 _____