Frisco Institute *for* Reproductive Medicine
Frisco Reproductive Surgery Center / Frisco IVF

8380 Warren Parkway, Suite 201, Frisco, TX 75034 Phone: (972) 377-2625

PATIENT INTAKE INFORMATION

(Please complete using **BLACK INK**)

DATE: _____

Women: Current OB/GYN: _____ OB/GYN Phone: _____

Men: Current PCP: _____ PCP Phone: _____

PATIENT NAME: _____ BIRTH DATE: _____
Last First MI

AGE: _____ RACE (Optional): _____ ETHNICITY (Optional): _____

SSN: __ __ __-__ __- __ __ __ __ E-MAIL ADDRESS: _____

HOME PHONE: _____ May we leave a message? ☐ Yes or ☐ No

WORK PHONE: _____ May we leave a message? ☐ Yes or ☐ No

CELL PHONE: _____ May we leave a message? ☐ Yes or ☐ No

ADDRESS: _____

City: _____ State: _____ Zip: _____

EMPLOYMENT: ☐ Full time ☐ Part Time ☐ Not Employed ☐ Homemaker

Employer: _____ Occupation: _____

Employer address: _____ City/State/Zip: _____

PHARMACY Name: _____ Pharmacy Phone: _____ Pharmacy Fax: _____

MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Other: _____

NAME OF SPOUSE: _____
Last First MI

EMERGENCY CONTACT NAME: _____
Last First MI

RELATIONSHIP TO YOU: _____

HOME PHONE: _____ May we leave a message? ☐ Yes or ☐ No

CELL PHONE: _____ May we leave a message? ☐ Yes or ☐ No

Referred to clinic by: ☐ Family ☐ Friend ☐ Website ☐ Former Patient ☐ Physician ☐ Other _____

If referred by a physician: Physician Name: _____ Phone: _____

If referred by a friend or physician may be compose and mail a thank you letter? ☐ Yes ☐ No

INSURANCE INFORMATION: Policyholder: ☐ Self ☐ Spouse ☐ Parent

Is spouse covered on this plan? ☐ **Yes or** ☐ **No** ☐ **N/A**

Name of insurance carrier: _____ ☐ **HMO** ☐ **PPO** ☐ **POS** ☐ **EPO** ☐ **OAP**

Policy/Member #: _____ Group #: _____

Claims Address: _____

Member services phone: _____ Pre-Cert phone: _____

SECONDARY INSURANCE: Policyholder: ☐ Self ☐ Spouse

Is spouse covered on this plan? ☐ **Yes or** ☐ **No** ☐ **N/A**

Name of insurance carrier: _____ ☐ **HMO** ☐ **PPO** ☐ **POS** ☐ **EPO** ☐ **OAP**

Policy/Member #: _____ Group #: _____

Claims Address: _____

Member services phone: _____ Pre-Cert phone: _____

IF YOU ARE NOT THE POLICY HOLDER

First and last name of policy holder: _____

SSN: __ __ __-__ __- __ __ __ __ BIRTH DATE: _____

RELATIONSHIP TO YOU: _____

HOME PHONE: _____ May we leave a message? ☐ Yes or ☐ No

WORK PHONE: _____ May we leave a message? ☐ Yes or ☐ No

CELL PHONE: _____ May we leave a message? ☐ Yes or ☐ No

Please acknowledge receipt of Patient Bill of Rights and Notice of Privacy Practices: _____
(Initial)

I hereby certify that the above information is true and accurate: _____
(Signature)