ARIZONA CENTER FOR
REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY
5190 E. FARNESS DR. #114
TUCSON, ARIZONA 85712

PATIENT INFORMATION

Name _____

Address _____

City _____ State _____ ZIP _____ SSN _____

Home Phone _____ Work Phone _____ SEX ❑ M ❑ F

Date of Birth _____ Age _____ ❑ Single ❑ Married ❑ Divorced E-mail _____ Ethnicity _____

Referring Person (How did you hear about us?) _____

Patient's Employer _____

Spouse/Partner's Name _____ Date of Birth _____

Spouse/Partner's Employer _____

Medical Allergies: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Ins. Co. Name _____

Ins. Co. Address _____

Policy Holder _____

Relationship to patient _____

Policy ID# _____ Group# _____

Policy Holder's Date of Birth _____

SECONDARY INSURANCE

Ins. Co. Name _____

Ins. Co. Address _____

Policy Holder _____

Relationship to patient _____

Policy ID# _____ Group# _____

Policy Holder's Date of Birth _____

I understand that unless otherwise arranged office charges are payable at the time of service. I also understand that my health insurance coverage is an agreement between me and my insurance company and that I am responsible for payment of fees regardless of insurance coverage. State law, A.R.S.32-1401(25)(ff), requires that a physician notify the patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in a non-routine goods or services being prescribed by the physician, and if these are available elsewhere on a competitive basis. (I/We) support this law, because it helps patients make reasoned financial decisions concerning their medical care. We advise you that we have a financial interest in a diagnostic or treatment agency or in the non-routine goods of services named below. Further, as indicated, goods or services that we have prescribed are available elsewhere on a competitive basis.

In the event hospitalization and/or surgery become necessary I authorize my insurance company to make payment directly to Arizona Center for Reproductive Endocrinology and Infertility and I further authorize Arizona Center for REI to release to my insurance company any information necessary for payment of claims.

Patient Signature _____ Date _____

Responsible Party Signature _____ Date _____