



PATIENT REGISTRATION FORM

Hello! Welcome to our office. We are anxious to make you appointment as convenient as possible. Would you please help us by furnishing the information requested below. This will be used to complete your record and will be kept strictly confidential. Hilton I. Kort, M.D. F.A.C.O.G., Carlene W. Elsner, M.D., F.A.C.O.G., Dorothy Mitchell-Leef, M.D., F.A.C.O.G., Michael A. Witt, M.D., F.A.C.S., Daniel B. Shapiro, M.D., F.A.C.O.G., Andrew A. Toledo, MD., F.A.C.O.G., Scott M. Slayden, M.D. and Robert J. Straub, M.D. Reserve the right to assign any physician in their employ to participate in your medical care and that such assignment may be changed at their discretion. Should your address change at any time, please fill out another one of our information sheets. Should you ever need to cancel an appointment, please call and let the office know as soon as possible. If you have any questions about your care, your appointment or our fees, please feel free to discuss them with us. THANK YOU!

Please Print

Patient's Name _____
Home Address _____ City _____ State _____ Country _____
Zip Code _____ Telephone () _____ Marital Status _____ Age _____ Social Security # _____
Date of Birth _____ Race _____ Employed By _____ Occupation _____
City _____ State _____ Zip _____ Telephone () _____

Spouse's / Partner's Name _____
Home Address _____ City _____ State _____ Country _____
Zip Code _____ Telephone () _____

Referring Physician: _____ Phone #: _____

Nearest Relative (Not Living In Same Household) _____ Relationship _____ Telephone () _____
Home Address _____ City _____ State _____ Zip Code _____

Responsible Party (Complete Only If Different From Patient Or Spouse)

Name _____ Telephone () _____
Home Address _____ City _____ State _____ Zip _____
Employed By _____ Occupation _____ Business Address _____
City _____ State _____ Zip _____ Telephone () _____

Primary Insurance Company

Insurance Company _____
Insured Name _____
ID Number _____
Group Number _____
Phone Number For Benefits _____
Phone Number for Precerts _____
Claim Mailing Address _____

Secondary Insurance Company

Insurance Company _____
Insured Name _____
ID Number _____
Group Number _____
Phone Number For Benefits _____
Phone Number For Precerts _____
Claim Mailing Address _____

I, _____ hereby make assignment of all disability, surgical, medical and major insurance benefits to Hilton I. Kort, M.D., Carlene W. Elsner, M.D., Dorothy Mitchell-Leef, M.D., Michael A. Witt, M.D., Daniel B. Shapiro, Andrew A. Toledo, M.D., M.D., Scott M. Slayden, M.D. and Robert J. Straub, M.D., to release any medical information necessary to execute an assignment of benefits. I understand that regardless of any insurance coverage I might have, I am personally responsible for all charges to this account. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees should this be requested. I understand that I am responsible for services rendered and I agree to pay for services at the time of service. Insurance forms will be filed on hospital and surgery care only. I hereby authorize SOUTHEASTERN FERTILITY INSTITUTE and/or REPRODUCTIVE BIOLOGY ASSOCIATES to release any information acquired in the course of my examination and treatment to my insurance company or to another physician. I direct my insurance carrier to issue payment directly to SOUTHEASTERN FERTILITY INSTITUTE and/or REPRODUCTIVE BIOLOGY ASSOCIATES. I understand that I am financially responsible to SOUTHEASTERN FERTILITY INSTITUTE and/or REPRODUCTIVE BIOLOGY ASSOCIATES for any balance not covered by my insurance carrier. The cost of collection (30%) will be added to all delinquent accounts at the time they are placed with a collection agency.

PATIENT'S SIGNATURE

DATE

SPOUSE'S SIGNATURE

DATE