DAVID I. HOFFMAN, M.D., STEVEN J. ORY, M.D., MARCELO J. BARRIONUEVO, M.D., VANESSA N. WEITZMAN, M.D., DANIEL R. CHRISTIE, M.D., MARC R. GUALTIERI, M.D., LAURICE BOU NEMER, M.D. AND DR. LUIS R. HOYOS, M.D.
IVF FLORIDA REPRODUCTIVE ASSOCIATES

PLEASE ANSWER ALL QUESTIONS

DATE

PATIENT FIRST NAME | M.I. | LAST NAME

SEX (M F) | DATE OF BIRTH | AGE | MARITAL STATUS (CIRCLE ONE) SINGLE WIDOWED MARRIED DIVORCED | CELL PHONE

ADDRESS | CITY | STATE | ZIP CODE | HOME PHONE

EMPLOYER'S NAME AND ADDRESS | WORK PHONE

EMAIL ADDRESS

PRIMARY PHYSICIAN: _____

OB/GYN PHYSICIAN: _____

PARTNER

PARTNER'S FIRST NAME | M.I. | LAST NAME | PARTNER'S DATE OF BIRTH

ADDRESS | CITY | STATE | ZIP CODE

PARTNER'S EMPLOYER 'S NAME AND ADDRESS | WORK PHONE

PARTNER'S HOME PHONE | PARTNER'S CELL PHONE

PARTNER'S EMAIL ADDRESS

INSURANCE INFORMATION (Must be completed)

PRIMARY INSURANCE CARRIER | SUBSCRIBER NAME (POLICY HOLDER)

PATIENT'S RELATIONSHIP TO SUBSCRIBER | POLICY I.D. NUMBER | GROUP NUMBER

SECONDARY INSURANCE CARRIER • IF NOT APPLICABLE, ENTER N/A. | SUBSCRIBER NAME (POLICY HOLDER)

PATIENT'S RELATIONSHIP TO SUBSCRIBER | POLICY I.D. NUMBER | GROUP NUMBER

PARTNER'S INSURANCE | SUBSCRIBER NAME (POLICY HOLDER)

PARTNER'S RELATIONSHIP TO SUBSCRIBER | POLICY I.D. NUMBER | GROUP NUMBER

Assignment of Benefits - Authorization to Release Information - Financial Responsibility and Authorization to Treat.

I hereby assign all medical/surgical benefits, to include Major Medical benefits to which I am entitled , Including Medicare, private insurance and any other health plan to: IVF FLORIDA REPRODUCTIVE ASSOCIATES.

This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. The undersigned, whether signing as patient or partner, assumes financial responsibility for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment and to complete disability forms presented to me. Furthermore, the undersigned assumes responsibility for costs of collection, including reasonable attorney fees (in the trial or appellate courts).

I hereby authorize Drs. Hoffman, Ory, Barrionuevo, Weitzman, Christie, Gualtieri, Bou Nemer, Hoyos and their associates and staff to provide treatment for us.

PATIENT:_____DATE:_____

PARTNER:_____DATE:_____