



PATIENT INFORMATION (STS/LTS)

Patient Name: _____ Birthdate: ____/____/____
Marital Status (circle one): SINGLE MARRIED DIVORCED
Social Security: _____ - _____ - _____ Driver's License #: _____
Home Address: _____ City: _____
State: _____ Zip: _____ Home Phone: (____) _____
Employer: _____ Occupation: _____
Business Address: _____ City: _____
State: _____ Zip: _____ Business Phone: (____) _____
Allergies: Penicillin: YES NO Other: _____

Name of friend or relative (who will always know where to reach you):

_____ Phone: (____) _____

Referred by: _____ Phone: (____) _____

Address: _____

Reason for Semen Storage: Pre-Vasectomy I.V.F. Artificial Insemination
(Circle all that apply) Private Donor Directed Donor Surrogate
Cancer Therapy Type of Cancer: _____
Surgery What type? _____
List any surgery or other treatment you have had so far _____
List any surgery or other treatment you will be having _____

Policy Information

Payment is due at the time of service unless previous arrangements have been made. We accept cash, checks, master or visa cards. Our office follows the California Civil Code 1719 for all returned "bad" checks.

I would hereby acknowledge that should collection action become necessary, I agree to be responsible for all collection costs, and attorney's fees to collect the amount from me.

Authorized Signature: _____ Date: _____

Parent/Guardian Signature (If under 18 years old): _____