



REGISTRATION FORM

PATIENT INFORMATION			
First Name:		Last Name:	
Current address:			
City:	State:	Zip Code/Country:	
Phone (Day):	Phone (Eve):	Email:	
SSN:	Driver's license#:	Date of Birth (mmdyyyy):	
Employer Name:		Occupation:	
Employer Address:			
Referred by:			
Emergency Contact:		Phone:	
SPOUSE/PARTNER INFORMATION			
First Name:		Last Name:	
Current address:			
City:	State:	Zip Code/Country:	
Phone (Day):	Phone (Eve):	Email:	
SSN:	Driver's license#:	Date of Birth (mmdyyyy):	
PHYSICIAN INFORMATION			
First Name:		Last Name:	
Address:			
City:	State:	Zip Code/Country:	
Phone:	Fax:	Email:	
PRIVACY AND PAYMENT INFORMATION			
<p>Payment is due at the time of service unless previous arrangements are made. We accept cash, checks and certain credit cards. Our office follows the California Civil Code 1719 for all returned "bad" checks.</p> <p>The patient named above acknowledges that should collection become necessary, the patient agrees to be responsible for all collection costs and attorney fees to collect the amount for services rendered.</p> <p>Personal information such as Social Security Number (SSN) will only be used by our office to turn the account over to collection. The copy of the photo ID will only be used to verify and ensure that no one else can claim to be you to access your records. Furthermore, we do not share your personal information with marketing or sales companies under any circumstances. All information provided by you is used strictly by Fertility Center of California.</p>			
Patient Signature:		Date:	