FERTILITY CENTER
OF CALIFORNIA

REPRODUCTIVE TISSUE BANK SERVICES
ANONYMOUS DONOR SPERM
ANDROLOGY LABORATORY
SPERM CRYOBANKING
EMBRYO STORAGE

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): ______________________________