REPRODUCTIVE PARTNERS MEDICAL GROUP, INC.

Last Name	First Name	MI	Date of Birth	Age	Pt Acct # _____ BY GR DC AW AH GA MA CW

Home Address	City	State	Zip	Home Phone Number

E-Mail Address	Female Male (circle one)	Social Security Number	Work Phone Number

Drivers License	Marital Status S M D please circle one	Birthplace	Ethnic Origin	Cell Phone Number

Patient's Employer (name & address)	Occupation	

Spouse's/Partner's Name (Last Name, First Name)	Female Male (circle one)	Date of Birth	Age	Social Security Number

Spouse's/Partner's Employer (name & address)	Ethnic Origin	Cell Phone Number

E-Mail Address	Occupation

Name of Relative/Friend (not living with you) as an EMERGENCY CONTACT	Relationship	Phone Number

How did you hear about us?
If physician, address:
Physician's phone number:

* I understand that Reproductive Partners Medical Group, Inc. may bill my insurance as a courtesy. I will be held financially responsible for claims my insurance does not process in a timely manner.
* I understand if my account is delinquent after 60 days, I will be subject to collection proceedings, including but not limited to court costs and attorney's fees.
* Services desired that are not a covered benefit or are not authorized will be the financial responsibility of the patient at the time services are rendered.
* I authorize Reproductive Partners Medical Group, Inc. to release the requested and necessary information to my insurance company to complete my claim.
* I hereby authorize my insurance carrier to pay all my medical benefits, otherwise payable to myself, directly to Reproductive Partners Medical Group, Inc.
* LA/OC Surgical Center, Inc. is a wholly owned subsidiary of Reproductive Partners Medical Group, Inc.

PHONE CONSULTATIONS:

*I understand that RPMG physicians are licensed only in the State of California. I expressly agree that exclusive jurisdiction for any dispute with RPMG resides in the courts of the State of California; and I further agree and expressly consent to the exercise of personal jurisdiction in the courts of the State of California in connection with any such dispute including, without limitation, any claim involving RPMG and its affiliates, employees, contractors, agents, licensors and suppliers.

*Phone consultation fee must be paid in advance and will not be refunded unless the appointment is cancelled more than 24 hours in advance.

I confirm that I have read this entire form and the information provided above is true and correct. I understand and agree to the conditions stated above.

Signature _____ Date _____

Please provide your driver's license and insurance card so that we may make a photocopy at this time.

REPRODUCTIVE PARTNERS MEDICAL GROUP, INC.

9/13/16 dr HD face sheet