MONTGOMERY FERTILITY CENTER

Patient Registration

Please complete the entire form and print all information. Thank you

Last Name ______________________ First Name ______________________ MI ________

Address ____ Apt. #____________

City ______________________________________ State ______________ Zip ____________

Date of Birth ____________________Age __________ Sex __________ Social Sec # ____________________

Home Phone (____)______________Work (_____)________________ Cell (_____)____________________

Place of Employment ____

Address: ____________________________ City ______________ State __________ Zip __________

Is your health insurance through your employer? ☐ Yes ☐ No E-mail ____________________________

Referring Physician

Referring Physician Name ______________________________ Phone (____)____________________

Address ____________________________City ______________ State __________ Zip __________

Primary Care Physician ______________________________ Phone (______)________________________

Reason for visit ____

Person Responsible for Bill: ☐ Self ☐ Spouse ☐ Parent or Guardian

Last Name ______________________ First Name ______________________ MI __________

Address ____________________________ City ______________ State __________ Zip __________

Date of Birth ____________________ Age __________ Sex __________ Social Sec. # ____________________

Home Phone (_____)______________ Cell (_____)________________Place of Employment ____________________

Insurance Information

Primacy Insurance ______________________________ **Phone #** ______________________________

Policy # ____________________**Group** ____________________ **Policy holder's name** ____________________

Mailing address ______________________________ **Relationship to patient** ____________________

Authorization to Yemi A. Famuyiwa, M.D., F.A.C.O.G.

I hereby authorize payment of any medical insurance benefits for which I am entitled to be made directly to the above provider. I agree to pay the balance of any charges not paid or covered under my insurance plan. I also authorize release of medical information necessary to process any and all claims to Montgomery Fertility Center, Oluyemisi Famuywia, M.D., F.C.A.O.G. and Atlas Healthcare Management LLC as their billing agent.

Signature ____ **Date** ____________________

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