Western Fertility Institute

Patient Information:

First Name:_____ Middle Name_____ Last Name_____

Address:_____ City_____ State_____ Zip_____

Social Security_____ Drivers License_____ Date of Birth_____

The following will be used to contact you regarding: Treatment, Payment, and messaging. Please leave items blank if you do not wish to be contacted using the number or email address.

Home Phone_____ Cell_____ Work_____

Preferred contact number: Home Cell Work Email:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Widower ☐ Domestic Partner
Do we have permission to release medical information to your partner?: ☐ Yes ☐ No
May we email you and your partner updates and office mailings to the above email address?: ☐ Yes ☐ No
Emergency Contact:_____ Relationship_____ Phone_____
I certify that the information on this form is true and correct to the best of my knowledge. Should there be any changes in the above information I will notify the office of these changes immediately. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any services rendered.

Signature: _____ Date: _____

Partner Information:

First Name:_____ Middle Name_____ Last Name_____

Address:_____ City_____ State_____ Zip_____
(If different than above)

Social Security_____ Drivers License_____ Date of Birth_____

The following will be used to contact you regarding: Treatment, Payment, and messaging. Please leave items blank if you do not wish to be contacted using the number or email address.

Home Phone_____ Cell_____ Work_____

Preferred contact number: Home Cell Work Email:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Widower ☐ Domestic Partner
Do we have permission to release medical information to your partner?: ☐ Yes ☐ No
May we email you and your partner updates and office mailings to the above email address?: ☐ Yes ☐ No
Emergency Contact:_____ Relationship_____ Phone_____
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Signature: _____ Date: _____