

# THE CENTER FOR REPRODUCTIVE AND HORMONE BALANCE

## PATIENT INFORMATION

NAME-FIRST	MIDDLE	LAST	SOCIAL SECURITY #
STREET ADDRESS		CITY	STATE ZIP
HOME PHONE		WORK PHONE	
EMPLOYER		OCCUPATION	
EMPLOYER ADDRESS		CITY	ST. ZIP

## PARTNER INFORMATION

NAME-FIRST	MIDDLE	LAST	SOCIAL SECURITY #
STREET ADDRESS		CITY	STATE ZIP
HOME PHONE		WORK PHONE	
EMPLOYER		OCCUPATION	
EMPLOYER ADDRESS		CITY	ST. ZIP

## EMERGENCY CONTACT PERSON (If other than listed above)

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE
STREET ADDRESS		CITY	ST. ZIP

## INSURANCE INFORMATION

<i>PRIMARY</i>		<i>SECONDARY</i>	
INSURANCE COMPANY NAME		INSURANCE COMPANY NAME	
ID #	GROUP #	ID #	GROUP #

## RESPONSIBLE PARTY

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE
STREET ADDRESS		CITY	ST. ZIP

## TO WHOM MAY WE DISCLOSE YOUR HEALTHCARE INFORMATION

NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP

I understand that I am ultimately financially responsible for any and all charges incurred regardless of my insurance coverage. I understand that The Center for Reproductive and Hormone Balance (CRHB) will bill insurance as required by insurance contract provisions for those plans that CHB is currently contracted with. I hereby authorize CRHB to release all or part of my medical records and information necessary upon written request by my insurance company.

I have reviewed the Notice of Privacy Practices and I give my permission to The Center for Reproductive and Hormone Balance to use and disclose my health information in accordance with it.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent if patient is a minor \_\_\_\_\_