Patient Registration Form

Henry Fertility ***Michael A. Henry, M.D.***

____ **Methodist Medical Plaza North**
201 Pennsylvania Parkway, Suite 325
Indianapolis, IN 46280
Office: (317) 817-1800 or Toll Free: (888) 305-6795
Fax: (317) 817-1810

____ **Professional Office Building, AP&S Clinic**
1429 N 6th Street - 2nd Floor
Terre Haute, IN 47807
Office: (888) 305-6795
Fax: (317) 817-1810

____ **Lafayette Women's Clinic**
3920 E. St. Francis Way, Ste. 219
Lafayette, IN 47904
Office: (888) 305-6795
Fax: (317) 817-1810

___ **Aegis Women's Clinic**
2920 McIntire Drive, Ste 250
Bloomington, IN 47403
Office: (888) 305-6795
Fax: (317) 817-1810

___ **Southern IN Physicians for Women**
1010 W 2nd Street
Bloomington, IN 47403
Office: (888) 305-6795
Fax: (317) 817-1810

Appointment Day Appointment Date Appointment Time

PATIENT INFORMATION

Last Name: First Name: Middle Initial:

Maiden Name: E-Mail Address:

Address: City: State: Zip Code:

Home Phone: Cell Phone: DOB: Age: Sex:

SS#: Marital Status:

PHYSICIAN INFORMATION

Primary Care Physician: Address:

City: State: Zip Code: Phone:

Referring M.D. Address

City: State: Zip Code: Phone:

How did you learn about our medical practice?

EMPLOYMENT INFORMATION

Employer: Business Phone:

Street Address: City: State: Zip Code:

Occupation: May we contact you at work? Hours:

SPOUSE OR SIGNIFICANT OTHER INFORMATION

Name: DOB: SS#: Cell Phone:

Employer: Business Phone: Occupation:

Address: City: State: Zip:

INSURANCE INFORMATION

Company ID#: Group#: Phone:

Insurance through (circle one): Patient Spouse Significant Other Parent Other

Please list social security number and date of birth of person who carries you on insurance if not already listed above:

SS#: DOB:

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IN CASE OF EMERGENCY CONTACT: (OTHER THAN SPOUSE)

Name: Relationship:

Home Phone: Work Phone: Cell Phone:

Address:

Consent to Treat: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Initial_____

Assignment and Release: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

Initial_____

Financial Agreement: I understand the fees for all services rendered are the full responsibility of the patient. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Initial_____

I understand the above and fully understand the terms thereof:

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

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