

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: ** FEMALE PATIENT ONLY **

Last Name:		First Name:		Middle Initial:	
Maiden Name:		E-Mail Address:			
Address:		City:		State:	Zip Code:
Home Phone:	Cell Phone:	DOB:	Age:	Sex:	
SS#:	Ethnicity:		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

Gender: Male Female Other _____

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: _____

PREFERRED METHOD OF CONTACT: _____ Email _____ home phone _____ cell phone

Our preferred method of contact is by email. If you prefer to be contacted by phone, check here _____

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