

PATIENT INTAKE FORM

WHO REFERRED YOU / HOW DID YOU HEAR ABOUT OUR PROGRAM?

<input type="checkbox"/> Physician*	<input type="checkbox"/> Other Patient	*Physician Name: _____
<input type="checkbox"/> Self-referred	<input type="checkbox"/> Other Method: _____	Street Address: _____
<input type="checkbox"/> Internet/Web Site		City: _____ Phone: _____
<input type="checkbox"/> Insurance Directory		Specialty: _____

WIFE

HUSBAND

SOCIAL SECURITY NO:		PATIENT ID NO:	
NAME (LAST, FIRST, MIDDLE INITIAL)			
ADDRESS			
CITY/STATE/ZIP			
HOME PHONE	WORK PHONE	MOBILE PHONE	
DATE OF BIRTH	AGE		
SINGLE	MARRIED	MARRIAGE DATE	ENGAGEMENT DATE
CAN WE CONTACT YOU BY E-MAIL? E-MAIL ADDRESS: _____			

SOCIAL SECURITY NO:		PATIENT ID NO:	
NAME (LAST, FIRST, MIDDLE INITIAL)			
ADDRESS (IF DIFFERENT FROM WIFE)			
CITY/STATE/ZIP			
HOME PHONE	WORK PHONE	MOBILE PHONE	
DATE OF BIRTH	AGE		
SINGLE	MARRIED	MARRIAGE DATE	ENGAGEMENT DATE
CAN WE CONTACT YOU BY E-MAIL? E-MAIL ADDRESS: _____			

Wife's Employment

COMPANY NAME	OCCUPATION
ADDRESS	
CITY/STATE/ZIP	

Husband's Employment

COMPANY NAME	OCCUPATION
ADDRESS	
CITY/STATE/ZIP	

Wife's Primary Insurance

INSURANCE COMPANY NAME	
POLICY HOLDER NAME	
POLICY #	GROUP #

Husband's Primary Insurance

INSURANCE COMPANY NAME	
POLICY HOLDER NAME	
POLICY #	GROUP #

Wife's Secondary Insurance

INSURANCE COMPANY NAME	
POLICY HOLDER NAME	
POLICY #	GROUP #

Husband's Secondary Insurance

INSURANCE COMPANY NAME	
POLICY HOLDER NAME	
POLICY #	GROUP #

Emergency Contact

NAME	DAY PHONE	NIGHT PHONE	RELATIONSHIP
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I hereby allow payment of authorized insurance benefits to Dr. Vincent Brandeis and NY and NJ Reproductive Services PC for services rendered by Dr. Brandeis as specialist provider in my insurance plan.

I also authorize the release of personal health information about me to the Health Care Financing Administration and its agents or authorized insurance companies needed to process claims submitted on my behalf by Dr. Brandeis.

I understand if plans require referrals or authorizations, they must be obtained prior to services being rendered.

Husbands are not covered under referrals or authorizations issued for wives.

Signature (Wife): _____ **Date:** _____
Signature (Husband): _____ **Date:** _____