HUNTINGTON
Reproductive Center
MEDICAL GROUP
REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY

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1220 La Venta, Suite 103
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West Los Angeles, CA. 92835
Tel: (310) 481-0881

23961 Calle de la Magdalena,
Suite 541, Laguna Hills, CA. 92653
Tel: (949) 472-9446

PATIENT REGISTRATION FORM

PATIENT'S ACCOUNT #			CHART NUMBER	CATEGORY
NAME (LAST, FIRST INIT.)		**HOME PHONE NO.**	**DOB**	AGE
ADDRESS	CITY		STATE	ZIP CODE
SOCIAL SECURITY NO.	DL#	SEX (M/F)	MARITAL STATUS	ETHNICITY
OCCUPATION	EMPLOYER		EMAIL ADDRESS	
WORK ADDRESS	CITY		STATE	ZIP CODE
WORK PHONE NO.	**REFERRAL**	IN CASE OF EMERGENCY CONTACT PERSON AND PHONE NO.		

PRIMARY INSURANCE INFO. PLEASE PROVIDE COPY OF INSURANCE CARD	INSURANCE NAME & ADDRESS		
SUBSCRIBER NO.	GROUP NO.	COVERAGE FROM	COVERAGE TO
ANNUAL DEDUCTIBLE	DEDUCTIBLE MET	CO-PAYMENT	% OF COVERAGE	PAY PLAN
CLAIM NUMBER	INSURED'S NAME	INSURED'S DATE OF BIRTH		

SECONDARY INSURANCE INFO. PLEASE PROVIDE COPY OF INSURANCE CARD	INSURANCE NAME & ADDRESS		
SUBSCRIBER NO.	GROUP NO.	COVERAGE FROM	COVERAGE TO
ANNUAL DEDUCTIBLE	DEDUCTIBLE MET	CO-PAYMENT	% OF COVERAGE	PAY PLAN
CLAIM NUMBER	INSURED'S NAME	INSURED'S DATE OF BIRTH		

PARTNER'S NAME (LAST, FIRST INIT.)	ACCT.	**HOME PHONE NO.**	**DOB**	AGE
ADDRESS	CITY		STATE	ZIP CODE
SOCIAL SECURITY NO.	DL#	SEX (M/F)	MARITAL STATUS	ETHNICITY
OCCUPATION	EMPLOYER		EMAIL ADDRESS	
PARTNER'S WORK ADDRESS	CITY		STATE	ZIP CODE
WORK PHONE NO.	**REFERRAL**	IN CASE OF EMERGENCY CONTACT PERSON AND PHONE NO.		

I authorize payment of medical benefits be made directly to the physician provider for services rendered. I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information to this claim and the expenses reported.
I understand and agree that (regardless of any insurance status) I am ultimately responsible for any balance on my account and for any services rendered.

Signed (Insured or Authorized) _____ Signed (Partner) _____ Date _____

By becoming a patient at HRC, I/we give our consent to be evaluated and treated for reproductive endocrine and infertility issues. I understand that routine medical care, such as pap smears will be performed by my PCP or OB/GYN.

Signed (Insured or Authorized) _____ Signed (Partner) _____ Date _____