WAYNE S. MAXSON, M.D., DAVID I. HOFFMAN, M.D., STEVEN J. ORY, M.D., MARCELO J. BARRIONUEVO, M.D., DEBBRA A. KEEGAN, M.D., VANESSA N. WEITZMAN, M.D., and GENE F. MANKO, M.D.
IVF FLORIDA REPRODUCTIVE ASSOCIATES

PLEASE ANSWER ALL QUESTIONS

DATE

PATIENT NAME	SEX M F	DATE OF BIRTH	AGE	MARITAL STATUS (CIRCLE ONE) SINGLE WIDOWED MARRIED DIVORCED

ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ( )

EMPLOYER'S NAME AND ADDRESS	WORK PHONE ( )

OCCUPATION	LENGTH OF EMPLOYMENT	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER/STATE	ALTERNATE PHONE NUMBER

EMAIL ADDRESS	REFERRED BY ☐ INTERNET ☐ FRIEND ☐ PHYSICIAN: ____________ ☐ OTHER: ____________

PARTNER

PARTNER'S NAME	PARTNER'S DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP CODE

PARTNER'S EMPLOYER'S NAME AND ADDRESS

PARTNER'S WORK PHONE NO.	PARTNER'S OCCUPATION	LENGTH OF EMPLOYMENT	PARTNER'S SOCIAL SECURITY NO.	PARTNER'S DRIVER'S LICENSE NUMBER

INSURANCE INFORMATION (Must be completed)

PRIMARY INSURANCE CARRIER	ADDRESS	SUBSCRIBER NAME (POLICY HOLDER)
PATIENT'S RELATIONSHIP TO SUBSCRIBER	POLICY I.D. NUMBER	GROUP NUMBER
SECONDARY INSURANCE CARRIER	ADDRESS	SUBSCRIBER NAME (POLICY HOLDER)
PATIENT'S RELATIONSHIP TO SUBSCRIBER	POLICY I.D. NUMBER	GROUP NUMBER
PARTNER'S INSURANCE	ADDRESS	SUBSCRIBER NAME (POLICY HOLDER)
PARTNER'S RELATIONSHIP TO SUBSCRIBER	POLICY I.D. NUMBER	GROUP NUMBER

Assignment of Benefits - Authorization to Release Information - Financial Responsibility and Authorization to Treat.

I hereby assign all medical/surgical benefits, to include Major Medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to: IVF FLORIDA REPRODUCTIVE ASSOCIATES.

This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. The undersigned, whether signing as patient or partner, assumes financial responsibility for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment and to complete disability forms presented to me. Furthermore, the undersigned assumes responsibility for costs of collection, including reasonable attorney fees (in the trial or appellate courts).

I hereby authorize Drs. Maxson, Hoffman, Ory, Barrionuevo, Keegan, Weitzman, Manko and their associates and staff to provide treatment for us.

PATIENT: ______________________________ DATE: ______________

PARTNER: ______________________________ DATE: ______________