Patient First Name	**Patient Last Name**	Date of Birth	Age	Sex	Social Security #
Address		City		State	Zip Code
Home Phone Number	Cell Phone Number		Work Phone Number		
Marital Status	Sexual Orientation	Ethnicity	Email Address		
Occupation	Employer		Emergency Contact and Phone#		
Primary Insurance: (Please Provide copy of insurance Card)					
Subscriber ID#	Insured's Name		Insured's Date of Birth		
Secondary Insurance: (Please Provide copy of insurance Card)					
Subscriber ID#	Insured's Name		Insured's Date of Birth		
Preferred Method on contact: ☐ Cell Phone ☐ Email ☐ Home Phone ☐ Work Phone					

Partner First Name	**Partner Last Name**	Date of Birth	Age	Sex	Local pharmacy #
Address		City		State	Zip Code
Home Phone Number	Cell Phone Number		Work Phone Number		
Marital Status	Sexual Orientation	Ethnicity	Email Address		
Occupation	Employer		Emergency Contact and Phone#		

Referral to Center:
Physician Name: _____
_____
Friend/Family Name: _____
_____
Internet? Specify: _____
Yelp__Healthgrades__PFCLA
Resolve __Google__ Yahoo___
Other: _____

Primary Care Physician:
Name: _____
_____
Phone#_____
Address: _____
_____
City: _____
State:_____ Zip Code:_____

OB/Gyn:
Name: _____
_____
Phone#_____
Address: _____
_____
City: _____
State:_____ Zip Code:_____

Your records are considered confidential information and we will not release any information without your consent and signature. Please sign the release below. ***I hereby authorize CMD Fertility to release information t myself, my insurance carrier and to my physician.***

Patient Signature: _____ **Date: _____**

Partner Signature:_____ **Date: _____**

CONSENT TO THE USE AND DISCLOSURE FO HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH OPERATION

I hereby acknowledge receipt of a written notice of my privacy rights and I consent to CMD FERTILITY using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been given access to the Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that CMD FERTILITY reserves the right to change their notice and information practices and that I may obtain a copy of the revised noticed by written request addressed to: CMD FERTILITY, 10921 Wilshire Blvd Suite #702, Los Angeles, CA 90024.

I understand that I have the right to restrict how CMD FERTILITY uses or discloses my protected health information to carry out treatment, payment or health care operations; that CMD FERTILITY is not required to agree to the restrictions and; that CMD FERTILITY is bound by restrictions to which it agrees.

I request the following restrictions to how my health information is used to disclose:

I have the right to revoke this consent by notifying CMD FERTILITY in writing, except to the extent that CMD FERTILITY has taken action in reliance to my consent.

Patient Name: _____ Signature: _____ Date: _____