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|  |
| **Your Information** |
| **Last Name:** | **First Name:** | **Middle Name:** |
|       |       |       |
| **Date of Birth:** | **Gender:** |  |
|       | **[ ]**  **MALE** | **[ ]  FEMALE** |
| **Address:** | **Apt/Suite # (If Applicable):** |
|       |       |
| **Zip:** | **City:** | **State:** |
|       |       |       |
| **Cellular Phone:**     Do we have your permission to leave a voice message on the cellular phone number provided?**[ ]  YES [ ]  NO** | **Alternate Phone:**     Do we have your permission to leave a voice message on the alternate phone number provided?**[ ]  YES [ ]  NO** | **E-Mail:**      |
| **Race/Ethnicity:** | **[ ]  African American** | **[ ]  Asian** | **[ ]  Caucasian** | **[ ]  French Canadian** | **[ ]  Hispanic** |
|  | **[ ]  Jewish (Ashkenazi)** | **[ ]  Jewish (Sephardic)** | **[ ]  Mediterranean** | **[ ]  Other:**       |
| **Your Insurance Information** |
| **Insurance Name:** | **Policy ID:** | **Group ID (If Applicable):** |
|       |       |       |
| **\*\*PLEASE HAVE YOUR INSURANCE CARD READY WHEN YOU ARRIVE FOR YOUR APPOINTMENT\*\*** |
| **Family History (If Applicable)** |
| **Do you have any family history of any genetic disorders?** | **[ ]  YES** | **[ ]  NO** |
| ***If Yes\**:** | **Name of Disorder(s):**       | **Family Relationship:**       |
| **Affected or Carrier?:**       | **Mutation, if known:**       |
| **Your Partner’s Information (If Applicable)** |
| **Please Note:** Your partner is also required to fill out a Patient Pre-Registration Form if being tested |
| **Last Name:** | **First Name:** | **Date of birth:** |
|       |       |       |

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| **Questionnaire** |
| 1. **Do you consent to genetic carrier screening testing? [ ]  YES [ ]  NO**
 | **[ ]  YES [ ]  NO** |
| 1. **Are you currently trying to conceive?**
 | **[ ]  YES** **[ ]  NO** |
| 1. **Are you interested in pre-conception counseling with**

**Dr.       at      ?**  | **[ ]  YES [ ]  NO** |
| 1. **Where did you first hear about this event?**
 |  |

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