AUSTIN FERTILITY SURGERY CENTER

PRE-ADMISSION FORM

Physician Name:_____

PATIENT INFORMATION: (PLEASE PRINT)

NAME LAST			FIRST		MI	
SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	SEX	MARITAL STATUS		
HOME PHONE	CELL PHONE		EMAIL ADDRESS			
HOME ADDRESS STREET		APT#	CITY		STATE	ZIP
EMPLOYER			OCCUPATION			
PARTNER NAME LAST	FIRST	MI	DATE OF BIRTH	AGE	SEX	HOME PHONE/CELL PHONE

Ethnicity/Race: ❒Asian ❒Black/African American ❒Spanish/Hispanic/Latino ❒American Indian/Alaska Native ❒Native Hawaiian/Pacific Islander ❒Multiracial ❒Caucasian ❒Other

INSURANCE INFORMATION ***Only if your urological procedure (MESA/TESE/PESA) is a covered benefit:***

(PROVIDE COPY OF FRONT & BACK OF INSURANCE CARD)

PRIMARY INSURANCE COMPANY			SECONDARY INSURANCE COMPANY		
PRIMARY SUBSCRIBER NAME	DOB	PRIMARY POLICY NO.	SECONDARY SUBSCRIBER NAME	DOB	SECONDARY POLICY NO.
PRIMARY SUBSCRIBER EMPLOYER	GROUP #	RELATION TO PATIENT	SECONDARY SUBSCRIBER EMPLOYER	GROUP #	RELATION TO PATIENT
INSURANCE MAILING ADDRESS CITY STATE ZIP			INSURANCE MAILING ADDRESS CITY STATE ZIP		
INSURANCE CLAIMS PHONE NUMBER			INSURANCE CLAIMS PHONE NUMBER		
PRE-CERTIFICATION PHONE NUMBER			PRE-CERTIFICATION PHONE NUMBER		

I understand that Austin Fertility Surgery Center is not contracted with any insurance companies including government sponsored health plans, such as Medicare, Medicaid, or Tricare and that payment in full is due at the time of service. I understand that upon request, Austin Fertility Surgery Center will submit a claim to my insurance company (excluding any government sponsored health plans) as a courtesy, and I acknowledge that it is my responsibility to contact them regarding the status of any claims submitted on my behalf. I authorize the release of any medical records or other information necessary to process my claim. By providing the above information, I have consented to be contacted by Austin Fertility Surgery Center at any of the above addresses or telephone numbers. I further agree that a photocopy of this agreement is as valid as the original.

Patient Signature_____Date:_____

****All pre-registration paperwork along with payment is due prior to your procedure date.**

****If you have anesthesia with your procedure, this information will be forwarded to Austin Anesthesia Group.**

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