

Rinehart Center for Reproductive Medicine

Initial Visit ___/___/___

Physician: ___Dr. Rinehart ___Dr. Coulam

Office: ___EV ___CS ___DG ___CHI

PATIENT REGISTRATION INFORMATION

PLEASE PRINT CLEARLY

Patient Last Name		First Name	Middle Initial
Street Address		City	State / Zip Code
Home Phone ()		Work Phone ()	Cell or Pager ()
Sex	Date of Birth	Current Age	Social Security Number
Patient's Employer, Name, Address and Phone			Occupation
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			

Primary Care Physician Name	Office Address and Phone
OB/Gyn Physician Name	Office Address and Phone

Partner's Last Name		First Name	Middle Initial
Home Phone ()		Work Phone ()	Cell or Pager ()
Sex	Date of Birth	Current Age	Social Security Number
Partner's Employer, Name, Address and Phone			Occupation
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			

Referral Source (<i>please check one, if applicable</i>): <input type="checkbox"/> Physician <input type="checkbox"/> Friend <input type="checkbox"/> Newspaper <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other
Referring Person's Name:
Referral Person's Address (<i>if a physician</i>):

PLEASE PRESENT YOUR INSURANCE CARD (S) FOR COPYING

Primary Insurance Company Name		Address and Phone	
Subscriber Name and Employer	Group #	Plan #	
Secondary Insurance Company Name		Address and Phone	
Subscriber Name and Employer	Group #	Plan #	

Emergency Contact Name	Relationship to Patient	Daytime Phone ()
Patient Signature		