

# REPRODUCTIVE PARTNERS MEDICAL GROUP, INC.

Last Name	First Name	MI	Date of Birth	Age	Pt Acct # _____ BY GR DC AH GA MA CW
Home Address		City	State	Zip	Home Phone Number
E-Mail Address		Female Male (circle one)	Social Security Number		Work Phone Number
Drivers License	Marital Status S M D please circle one	Birthplace	Ethnic Origin		Cell Phone Number
Patient's Employer (name & address)			Occupation		

Partner's Name (last name, first name)	Female Male (circle one)	Date of Birth	Age	Social Security Number
Partner's Employer (name & address)		Ethnic Origin		Cell Phone Number
E-Mail Address		Occupation		
Name of Relative/Friend (not living with you) as an EMERGENCY CONTACT		Relationship	Phone Number	
How did you hear about us? If physician, address and phone number:				

- \* I understand that Reproductive Partners Medical Group, Inc. may bill my insurance as a courtesy. I will be held financially responsible for claims my insurance does not process in a timely manner.
- \* I understand if my account is delinquent after 60 days, I will be subject to collection proceedings, including but not limited to court costs and attorney's fees.
- \* Services desired that are not a covered benefit or are not authorized will be the financial responsibility of the patient at the time services are rendered.
- \* I authorize Reproductive Partners Medical Group, Inc. to release the requested and necessary information to my insurance company to complete my claim.
- \* I hereby authorize my insurance carrier to pay all my medical benefits, otherwise payable to myself, directly to Reproductive Partners Medical Group, Inc.
- \* LA/OC Surgical Center, Inc. is a wholly owned subsidiary of Reproductive Partners Medical Group, Inc.
- \* I understand that RPMG physicians are licensed only in the State of California. I expressly agree that exclusive jurisdiction for any dispute with RPMG resides in the courts of the State of California; and I further agree and expressly consent to the exercise of personal jurisdiction in the courts of the State of California in connection with any such dispute including, without limitation, any claim involving RPMG and its affiliates, employees, contractors, agents, licensors and suppliers.

I confirm that I have read this entire form and the information provided above is true and correct. I understand and agree to the conditions stated above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please provide your and your partner's driver's licenses and insurance cards so that we may make a photocopy at this time.**