



WESTCHESTER FERTILITY & REPRODUCTIVE ENDOCRINOLOGY

136 South Broadway, Suite 100, White Plains, NY 10605

Telephone: (914) 949-6677

REGISTRATION (PLEASE PRINT)

Date _____

Home Phone _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Spouse _____
Last Name First Name Initial

Soc. Sec. # _____ Sex M F Age _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Spouse employed by _____ Occupation _____

Business address _____ Business phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ Name of Insurance Company(ies)
and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the follow payment options:

____ Payment by cash

____ Payment by check

____ Payment by credit card

____ Automatic monthly billing to your Visa and MasterCard

____ Guarantee your insurance co-payments with Visa or MasterCard

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa/MasterCard Health Care Incentive Program* which will enable you to use your Visa/MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

If none of the above apply, please see the office manager. Thank you.

Print your name here and sign below

x _____

Date: _____