

**PATIENT REGISTRATION**  
**Reproductive Care of Indiana**

[www.reprocareindiana.com](http://www.reprocareindiana.com)

<input type="checkbox"/> 201 Pennsylvania Pkwy Suite 310 Indianapolis, IN 46280 Phone (317) 817-1800 Fax (317) 817-1810 Toll Free (888) 365-3436	<input type="checkbox"/> 2316 South St. Lafayette, IN 47904 Phone (888)365-3436 Fax (317) 817-1810	<input type="checkbox"/> 1530 North 7 <sup>th</sup> St. Terre Haute, IN 47807 Phone (888)365-3436 Fax (317) 817-1810	<input type="checkbox"/> 2920 McIntire Dr. Suite 250 Phone (888)365-3436 Fax (317) 817-1810	<input type="checkbox"/> 1115 Ronald Reagan Pkwy Suite 324 Avon, IN 46123 Phone (888) 365-3436 Fax (317) 817-1810
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Day \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Patient's Name _____			
(Last)	(First)	(Middle Initial)	
Maiden Name _____	Mother's First Name _____		
Patient Address _____			
(Street)	(City)	(State)	(Zip Code)
Home Phone _____	Cell Phone _____	DOB _____	Age _____ Sex _____
SS# _____	Marital Status _____		

Primary Care Physician \_\_\_\_\_ Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

Referring M.D. \_\_\_\_\_ Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

How did you learn about our medical practice? \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Occupation \_\_\_\_\_ May we contact you at work? \_\_\_\_\_ Hours \_\_\_\_\_

**SPOUSE OR SIGNIFICANT OTHER INFORMATION**

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ SS# \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_ Occupation: \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**INSURANCE INFORMATION**

Company \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_ Phone \_\_\_\_\_

(Please check correct answer)

Insurance through: Patient \_\_\_\_\_ Spouse \_\_\_\_\_ Significant Other \_\_\_\_\_ Parent \_\_\_\_\_ Other \_\_\_\_\_

Please list social security number and date of birth of person who carries you on insurance if not already listed above:

SS# \_\_\_\_\_ D.O.B. \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT: (OTHER THAN SPOUSE)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_

**Reproductive Care of Indiana  
201 Pennsylvania Parkway, Suite 310  
Indianapolis, IN 46280  
317-817-1800**

**Consent to Treat:** I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Initial \_\_\_\_\_

**Assignment and Release:** I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

Initial \_\_\_\_\_

**Financial Agreement:** I understand the fees for all services rendered are the full responsibility of the patient. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Initial \_\_\_\_\_

I understand the above and fully understand the terms thereof:

\_\_\_\_\_  
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

**PLEASE MAIL THIS FORM TO OUR OFFICE PRIOR TO YOUR SCHEDULED  
APPOINTMENT.**

**THANK YOU!**