Pacific Reproductive Services

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Pasadena, CA 91101
Tel: (626) 432-1681 Fax: (626) 432-6869

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RECIPIENT ACCOUNT SET-UP & REGISTRATION FORM

Date _____/_____/_____

CLIENT Name ___________________________________ Email_______________________

ADDRESS Street____

City______________________________ State________ Zip______________________

Phone (____)________________ H / W Circle Cell (____)__________________

Date of Birth _____/_____/_____SS#__________

Driver's License # _________________________________ State ________________

(CHANGE) Street ____

(PRS use only) City _______________________________________ State _______ Zip __________

Phone (____)______________ H / W circle Cell (____)________________

PARTNERSHIP STATUS

☐Single ☐Married ☐Partnered If Registered Domestic Partnership, in what State:_____________

PARTNER Name ___________________________________ Email_______________________

☐Female Street ____

☐Male City______________________________________ State_____ Zip___________

Phone (____) _______________ H / W circle Cell (____)__________________

IS IT PERMISSIBLE TO CALL AND/OR LEAVE DETAILED MESSAGES ON:

____Client's Home answering machine? ____Partner's Home answering machine?

____Client's Work number? ____Partner's Work number?

____Identify as "PRS" only ____Email?

OCCUPATION ____

BUSINESS Street ____

ADDRESS City______________________________________ State_____ Zip___________

Phone (___)________________ Change (____)________________

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FOUND PRS THROUGH

☐Internet (which site?) ______________________________
☐Phone Book______________________________
☐Friend ______________________________
☐Advertisement (name of periodical)______________________________
☐Physician Referral (name and city)______________________________
☐Other (please specify)______________________________

FRIEND/RELATIVE
(for emergency use)

Name______________________________
Street______________________________
City______________________________ State________ Zip______________
Phone (____)____________ H / W circle Cell (____)_________________

LONG DISTANCE RECIPIENTS:

Please remember to return the following items with this Form:

___Patient Agreement ___Registration Fee ___Medical Certification Form signed by Clinician ___Notice of Privacy Practices Summary

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I give permission to charge my Credit Card:

______________________________ //_________________// ______________________________
VISA / MasterCard Number Expiration Date Name on Card

☐Card is Recipient's ☐Card is Partner's ☐Card is Other's

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Recipient or Other Signature