PRS Clinical Services

a division of the Genetics & IVF Institute, Inc.

Patient Registration Form

TODAY'S DATE / /

PATIENT CONTACT INFORMATION

Name Pronouns: Date of Birth / /

Street City State Zip

Best phone ( ) H W C Other ( ) H W C

SS# (or National ID#) Driver's license #

Email

Is it permissible to leave detailed messages at (check all that apply):

❑ Home phone ❑ Cell ❑ Work phone ❑ Partner or Spouse Cell ❑ Email

PARTNERSHIP STATUS: ❑ Single ❑ Married ❑ Partnered

PARTNER CONTACT INFORMATION Partner is: ❑ Male ❑ Female ❑ Non-Binary

Name Pronouns Email

Address ❑ Same address as client

City State Zip

Best Phone ( ) H W C Other ( ) H W C

Is it permissible to discuss your care and leave messages with your partner or spouse? ❑ Yes ❑ No

PATIENT OCCUPATION

Occupation Phone ( )

Business Address City State Zip

FOUND PRS THROUGH: ❑ Internet *(which site?)* ____________________ ❑ Periodical *(name)* ____________________

❑ MD Referral *(name)* ____________________ ❑ Friend ❑ Other *(please specify)*____________________

EMERGENCY CONTACT *(for emergency use)*

Name Phone ( )

Street City State Zip

CREDIT CARD INFORMATION ❑ Please charge my credit card for the Intake Appointment fee ($150)

Card is: ❑ Visa ❑ Mastercard ❑ Discover ❑ Recipient's ❑ Partner's

Card No.: - - - Exp. Date: /

Name on Card Signature Billing zip:

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