

ADVANCED REPRODUCTIVE CARE CENTER

7501 Las Colinas Blvd, Ste 200, Irving, TX 75063
Phone (972) 506-9986 Fax (972) 506-0044

919 West Randol Mill Rd, Arlington, TX 76012
Phone 817-701-1290 Fax 817-701-1297

GENERAL INFORMATION

Date (Fecha) _____

Chart# _____

Patient Name _____
(Paciente) First (Nombre) Middle (Inicial) Last (Apellido)

Home Address _____
Street (Direccion)

City _____ State _____ Zip _____
(Ciudad) (Estado) (Postal)

Telephone Home (Casa)# _____ Work (Trabajo)# _____ Cell# _____
(Casa #) (Trabajo) (Celular)

Birthdate _____ Age _____ SSN # _____
(Fecha de Nacimiento) (Edad) (Seguro Social)

Marital Status Married Single Divorced Occupation _____
(Marital) (Ocupacion)

Employer _____ Address (Direccion) _____
(Empleador)

Insurance Name _____ Insurance ID # _____ Group # _____
(Aseguranza) (Numero de Poliza)

Responsible Party Self Spouse Parent Other _____

Responsible Party's Name _____ Occupation _____

Responsible Party's Employer _____

Responsible Party's Employer Address _____

Name of Physician or person who referred you _____
(Quien le recomendo esta oficiano?)

Primary Care Physician (if applicable) _____

Emergency Contact Person _____ Phone # _____

INSURANCE AUTHORIZATION: I hereby authorize **Advanced Reproductive Care Center (ARCC) & Advanced Reproductive Laboratory (ARL)** to furnish information to my insurance carriers concerning my illness and treatment. I agree that if I fail to notify ARCC & ARL of insurance change or obtain required referrals or preauthorization for services, I will be responsible for those charges.

AUTORIZACION DE SEGURO: Autorizo **Advanced Reproductive Care Center & Advanced Reproductive Laboratory** que provea informacion medica de mi persona a las companias de seguro necesarias. Convengo que si no notifico ARCC & ARL del cambio del seguro u obtener requirió remisiones o el preauthorization para los servicios, yo seré responsable de esas cargas.

ASSIGNMENT OF BENEFITS: I hereby assign **Advanced Reproductive Care Center & Advanced Reproductive Laboratory** all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

AUTORIZACION DE BENEFICIOS: Asigno **Advanced Reproductive Care Center & Advanced Reproductive Laboratory** los beneficios del seguro, por servicios prestados a mi persona o dependientes mios. Entiendo que soy responsable por aquellos gastos no cubiertos por las companias de seguros.

Signature of Authorized Person (Firma de la Persona Autorizada)

Date (Fecha)