

NEW PATIENT INFORMATION FORM

We thank you for taking time to complete all of the information requested on this form. It is an important part of your personal medical record and enables us to provide you with needed follow up care. Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with Florida Fertility Institute or Tubal Reversal Experts.

Patient Information:

Full Legal Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Marital Status: M S D W

Home Phone: _____ Cell Phone: _____

Email Address: _____ Work Phone: _____

Employer: _____ Type of Work Performed: _____

Spouse's Name: _____ Spouse's Phone: _____

Patient must provide a valid Driver's License or Government Issued Photo ID

Doctor Information:

Name of Primary Care Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone#: _____ Fax#: _____

Name of OB/GYN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone#: _____ Fax#: _____

*Please note records will be sent to your OB/GYN after your surgery for your post-op visit.