Fertility & Surgical
ASSOCIATES OF CALIFORNIA

www.fertilityassociates.com

PATIENT'S INFORMATION **FSAC #:** _____ **TRI-COUNTY SURGERY CENTER #:** _____
Patient #:
(FOR OFFICE USE ONLY) (FOR OFFICE USE ONLY)

First Name: _____ **MI:** _____ **Last:** _____

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

Home Phone Number: _____ **Birth Date:** _____ **Age:** _____

Cell Phone Number: _____ **Alternative Phone Number:** _____ ☐ Male ☐ Female

Drivers License Number: _____ **Expiration Date:** _____

Social Security Number: _____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced

Occupation: _____ ☐ Widow ☐ Widower ☐ Domestic Partner

Employer: _____ **Work Phone Number:** _____

Do we have permission to leave a message for you or your partner on your home, cell, alt, or work phone number?: ☐ Yes ☐ No

Do we have permission to release medical information to your partner?: ☐ Yes ☐ No

Email Address: _____

May we email you or your partner's medical info, updates, and FSAC mailings to the above email address?: ☐ Yes ☐ No

Emergency Contact Person: _____ **Relationship to Pt.:** _____

Phone number where they can be reached: _____

How did you hear about us?: _____

I certify that the information on this form is true and correct to the best of my knowledge, and that I will notify FSAC of any changes. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any services rendered.

Signature: _____ **Date:** _____

PARTNER'S INFORMATION **FSAC #:** _____ **TRI-COUNTY SURGERY CENTER #:** _____
Patient #:
(FOR OFFICE USE ONLY) (FOR OFFICE USE ONLY)

First Name: _____ **MI:** _____ **Last:** _____

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

Home Phone Number: _____ **Birth Date:** _____ **Age:** _____

Cell Phone Number: _____ **Alternative Phone Number:** _____ ☐ Male ☐ Female

Drivers License Number: _____ **Expiration Date:** _____

Social Security Number: _____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced

Occupation: _____ ☐ Widow ☐ Widower ☐ Domestic Partner

Employer: _____ **Work Phone Number:** _____

Do we have permission to leave a message for you or your partner on your home, cell, alt, or work phone number?: ☐ Yes ☐ No

Do we have permission to release medical information to your partner?: ☐ Yes ☐ No

Email Address: _____

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Signature: _____ **Date:** _____