Fertility & Surgical
ASSOCIATES OF CALIFORNIA

www.fertilityassociates.com

PATIENT'S INFORMATION

FSAC #: ______________ (FOR OFFICE USE ONLY) LA - VENTURA SURGERY CENTER #: ______________ (FOR OFFICE USE ONLY)

First Name: ____________________ **MI:** ________ **Last:** ____________________

Address: ____________________ **City:** ____________ **State:** ______ **Zip:** ________

Home Phone Number: ____________________ **Birth Date:** ____________ **Age:** ________

Cell Phone Number: ____________ ____________ **Biological Sex:** □ M □ F □ Intersex_____

Driver's License Number: ____________________ **Expiration Date:** ____________________

Social Security Number: ____________________ **Marital Status:** □ Single □ Married □ Divorced

Occupation: ____________________ □ Widow □ Widower □ Domestic Partner

Employer: ____________________ **Preferred Pronouns:** ____________

Ethnicity: □ American Indian or Alaska Native □ Asian □ Black or African American □ Hispanic or Latino □ Native Hawaiian or other Pacific □ White □ Unknown □ Refused

Email Address: ____________________ **Gender:** □ Male □ Female □ Other__________

Do we have permission to call, leave a message, email, or text you or your partner on your home, cell, or email? □ Yes □ No
May we contact you via text or email to provide visit reminders, appointment scheduling, medical and educational information, mailings, or to request a review from you related to your care? □ Yes □ No

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

Emergency Contact: ____________________ **Emer Phone #:**____________ **Relationship to Pt.:** ______

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

FSMAC #: ______________ (FOR OFFICE USE ONLY) LA - VENTURA SURGERY CENTER #: ______________ (FOR OFFICE USE ONLY)

First Name: ____________________ **MI:** ________ **Last:** ____________________

Address: ____________________ **City:** ____________ **State:** ______ **Zip:** ________

Home Phone Number: ____________________ **Birth Date:** ____________ **Age:** ________

Cell Phone Number: ____________**Alternative Phone Number:** ____________ **Biological Sex:** □ M □ F □Intersex_____

Driver's License Number: ____________________ **Expiration Date:** ____________________

Social Security Number: ____________________ **Marital Status:** □ Single □ Married □ Divorced

Occupation: ____________________ □ Widow □ Widower □ Domestic Partner

Employer: ____________________ **Preferred Pronouns:** ____________

Ethnicity: □ American Indian or Alaska Native □ Asian □ Black or African American □ Hispanic or Latino □ Native Hawaiian or other Pacific □ White □ Unknown □ Refused

Email Address: ____________________ **Gender:** □ Male □ Female □ Other__________

Do we have permission to call, leave a message, email or text you or your partner on your home, cell, or email? □ Yes □ No
Do we have permission to release medical information to your partner? □ Yes □ No

Emergency Contact: ____________________ **Emer Phone #:**____________ **Relationship to Pt.:** ______

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Signature: ____________________ **Date:** ____________