Utah Center for Reproductive Medicine

Registration Form- shaded areas are required to complete your registration

Today's date ____________________

Name (legal)____
(First) (Last) (M.I.)

Date of birth ___/___/______ SS#_____-_____-______ Marital Status: Single M D W

Address ____ City __________________________

State _________ Zip Code __________ Phone# __________________Cell Phone #_________________
(Please include area code)

Driver's License # _______________________Mother's maiden name _______________________

Employer name____ (circle one) Full time/ Part time

Employer address _______________________________________ City _________________________

State ________ Zip Code ______________ Phone# ____
(Please include area code)

INSURANCE INFORMATION

Primary insurance

Policy ID# ____ Group # __________________________

Insurance company name ____

**Claims address ____ City _______________________

State_______ Zip Code _______________ Phone # ____
(Please include area code)

**Subscriber name _______________________________________ **Date of birth_______________

Relationship to Patient: (circle one) self spouse dependant child other **(specify)**___________________

Employer _______________________________________ Work phone _________________________

(Circle One) Full time / Part time

Secondary insurance

Policy ID# ____ Group # __________________________

Insurance company name ____

**Claims address ____ City _______________________

State_______ Zip Code _______________ Phone # ____
(Please include area code)

**Subscriber name _______________________________________ **Date of birth_______________

Relationship to Patient: (circle one) self spouse dependant child other **(specify)**___________________

Employer _______________________________________ Work phone _________________________

(Circle one) Full time / Part time

(PLEASE COMPLETE 2ndPAGE)

***GUARANTOR or PERSON RESPONSIBLE FOR ACCOUNT (IF other than the* patient)**

NAME ____SS #_____/_______/______

Address ____ City __________________________

State _________ Zip Code __________ Phone# _________________Cell Phone #_________________
(Please include area code)

Employer name____ (circle one) Full time/ Part time

Employer address ____ City _________________________

State ________ Zip Code ______________ Phone# ____
(Please include area code)

RELATIONSHIP TO PATIENT (Circle One) spouse parent or legal guardian other **(specify)**____________

EMERGENCY CONTACT INFORMATION

#1 NAME ____ Relationship______________________

Address ____ City __________________________

State _________ Zip Code __________ Phone# ____
(Please include area code)
ALT # ____
(Please include area code)

#2 NAME ____ Relationship______________________

Address ____ City __________________________

State _________ Zip Code __________ Phone# ____
(Please include area code)
ALT # ____
(Please include area code)

(Office use only)

Appt Day _________________ *Time* ______________ *Provider* __________________________________

VM# __________________________________*Appt type* ___________*MRN#* ________________________