



JARRETT FERTILITY GROUP

BUILDING FAMILIES SINCE 1985

Patient Information (please print)

Patients legal name: _____ Nickname _____
(last) (first) (MI)

Date of birth: _____ Age _____ Marital Status _____ Social Security No. _____

Street Address _____ Home Phone _____

City / State / Zip _____ Occupation _____

Employer _____ Work Phone _____

Employer's Street Address _____ City / State / Zip _____

Name of spouse/ parent (circle one) _____ Social Security No. _____

Occupation _____ Date of Birth _____

Employer _____ Work Phone _____

Employer's Street Address _____ City / State / Zip _____

Husband's street address, if divorced or separated _____ City / State / Zip _____

Relative or friend not residing with you _____ Home Phone _____

Street Address _____ City / State / Zip _____

Insurance Information

Person responsible for payment (if not patient) _____ Relationship _____ Home Phone _____

Primary insurance Co. _____ Effective Date _____ Policy No. _____

Insurance Mailing Address _____ City/State/Zip _____

Other (write in name of insurance co.) _____ Effective Date _____ Policy No. _____

Insurance Mailing Address _____ City/State/Zip _____

Referring Information

Have our physicians previously treated any member of your family? _____ If yes, who? _____

Referred by _____ Family Physician _____

It is customary to pay for services when rendered. all professional services are charged to the patient. the patient is responsible for all fees, regardless of insurance coverage.

INSURANCE AUTHORIZATION (PLEASE READ AND SIGN)

I hereby authorize Jarrett Fertility Group to furnish to insurance companies, or their representatives, information concerning my, or my dependent's illness and treatments. I hereby assign to Jarrett Fertility Group all payments for medical services rendered to my dependents or my self. I understand that I am responsible for any amount not covered by insurance and agree to pay for any collection and/or attorney fees if said unreimbursed amounts are not paid within a reasonable time period.

(Signature of insured) (Signature of patient or parent)

Date _____

- NORTH** 11725 Illinois Street, Suite 515 • Carmel, IN 46032 • Phone 317.814.4110 • Toll Free 888.674.0101 • Fax 317.814.4114
- WEST** 1111 Ronald Reagan Parkway, Suite • C-1100 Avon, IN 46123 • Phone 317.217.2525 • Toll Free 888.674.0101 • Fax 317.217.2535
- SOUTH** 8051 S. Emerson Avenue, Suite 410 • Indianapolis, IN 46237 • Phone 317.888.1242 • Toll Free 800.944.4743 • Fax 317.888.1557