BUFFALO INFERTILITY & IVF ASSOCIATES

4510 MAIN STREET · SNYDER, NEW YORK · 14226 · OFFICE 716-839-3057 · FAX 716-839-1477

PATIENT PERSONAL INFORMATION – ALL INFORMATION IS STRICTLY CONFIDENTIAL

Date: ____

Patient Name: ______________________________________

Date of Birth: ____________________________ Age: ______

Marital Status: _____________________________________

Address: ____

City: _________________________ State: ______ Zip: ______

Email:____

Social Security Number: _____________________________

Employer: ____

Employer Address: __________________________________

City: _________________________ State: ______ Zip: ______

Preferred contact number(s) **OK to leave voicemail**

Cell Phone: __________________________ □ Yes □ No

Home Phone: _________________________ □ Yes □ No

Work Phone: _________________________ □ Yes □ No

In case of Emergency, please notify (other than spouse/partner):

Name: ____

Phone #: ____

Relationship: _______________________________________

PREFERRED PHARMACY

Name ____

Address: ____

Phone # ____

Spouse/Partner's Name: _______________________________

Date of Birth: ____________________________ Age: ______

Marital Status: _____________________________________

Address: ____

City: _________________________ State: ______ Zip: ______

Email: ____

Social Security Number: _____________________________

Employer: ____

Employer Address: __________________________________

City: _________________________ State: ______ Zip: ______

Preferred contact number(s) **OK to leave voicemail**

Cell Phone: __________________________ □ Yes □ No

Home Phone: _________________________ □ Yes □ No

Work Phone: _________________________ □ Yes □ No

INSURANCE INFORMATION – PRIMARY (SELF)

Group Number: ______________________________________

Plan Name: ____

Name of Policy Holder: _______________________________

Date of Birth: _________________

ID Number: ______________________________ Suffix ____

Employer: ____

Member ID (Self) __________________________ Suffix ____

Relationship: ____

Insurance Effective Date: ______________________________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ____, and assign directly to Infertility & IVF Medical Associates of WNY all medical benefits. If any, otherwise payable to us for services rendered I understand that I am financially responsible for all charges whether or not paid by insurance, including 35% collection costs and 50% attorney fees. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and authorize the use of this signature on all submissions.

Signature of Insured: ____ Date: __________________________

Signature of Co-Insured: ____ Date: __________________________

MEDICARE AUTHORIZATION

I, the undersigned, request that payment of authorized Medicare benefits be made directly to Infertility & IVF Medical Associates of WNY for any services rendered to me. I authorize any medical information about me to be released to the Health Care Administration and its agents and to any other health insurance or on approved claim forms or electronically submitted claims. I understand my signature requests payments to be made. In Medicare assigned cases, Infertility & IVF Medical Associates of WNY agrees to accept Medicare charge determination and I am responsible only for the deductible, coinsurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Beneficiary's Signature: ____ Date: ____________________________