

Barry Witten, M.D.
Comprehensive Infertility Services

ALL CO-PAYS ARE DUE AT
TIME OF SERVICE

PATIENT INFORMATION

Today's Date: _____

Patient
Information

Name _____
FIRST MI LAST

If Married, Maiden Name _____ Mother's Maiden Name _____

Birthdate _____ Age _____ Soc. Sec. No. _____

Address _____

City _____ State _____ Zip _____

Phone: Home () _____ Work () _____

Cell # () _____ E-mail _____

Employer _____ Occupation _____

Employer Address _____

If Married, Husband's Name _____ Soc. Sec. No. _____

Husband's Birthdate _____ Occupation _____

Employer _____ Work Phone # () _____

Employer Address _____

Physician Referred by _____ Office Phone # () _____

Insurance
Information

Primary Insurance _____ Effective Date _____

Policy/ID No. _____ Group No. _____

Group Name _____

Subscriber Name _____ Relationship _____

Soc. Sec. No. _____

LIST ONLY IF COVERED

Secondary Insurance _____ Effective Date _____

Policy/ID No. _____ Group No. _____

Group Name _____

Subscriber Name _____ Relationship _____

Friend/Relative Not
Living With You

Name _____ Relationship _____

Cell # () _____ Home # () _____ Work # () _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any co-payments, deductible amounts, co-insurance, or any other balance not paid by your insurance carrier.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize the release of any medical or other information necessary to process this claim.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize payment of medical benefits to the physician or supplier of services rendered.

SIGNED _____ DATE _____

SIGNED _____ DATE _____