# INSTRUCTIONS FOR PATIENT REGISTRATION FORM

If you have a partner, please print 2 copies of this form. Each of you must complete a Patient Registration Form and return them to Boston IVF at least 1 week prior to your consultation.

Please complete this form in full, even if you think we already have this information. Incomplete forms will unfortunately be returned.

## PATIENT REGISTRATION FORM RETURN INSTRUCTIONS

If your appointment is in MA, NH, ME, or RI:
Fax (781) 370-0125 or email web.response@bostonivf.com

If your appointment is in Albany, NY:
Fax (518) 436-9822 or email dmcfadden@bivfnewyork.com

If your appointment is in Syracuse, NY:
Fax (315) 802-4688 or email LLydon@bivfnewyork.com

# PATIENT REGISTRATION FORM

Sex assigned at birth: ☐ Female ☐ Male

Gender Identity: _____ Preferred Pronouns: _____ Preferred Name: _____

Legal Name: _____ Date of Birth: _____

SSN: _____ Marital Status: _____

Partner Name, if applicable: _____ Partner DOB: _____

Address: _____ City, State, ZIP: _____

Home Phone: _____ ☐ Check if okay to leave a message

Cell Phone: _____ ☐ Check if okay to leave a message

Email Address: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Emergency Contact #: _____

Race - Please check all that apply (*Boston IVF is required by law to report patient race and ethnicity*):

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific ☐ White

☐ I'd prefer not to say ☐ I'm not sure ☐ Other: _____

Ethnicity:

☐ Hispanic ☐ Non-Hispanic ☐ I'd prefer not to say

☐ I'm not sure ☐ Other: _____

Language: _____ Nationality: _____

**Referring and Primary Care Physician (PCP)** (Please print full name and address of referring doctor and PCP)

Did a physician refer you to our practice? ☐ Yes ☐ No

If yes, who is the physician? _____ Address: _____

If no, how did you hear about our practice? _____

Primary Care Physician Name: _____ Address: _____

OB/GYN Name (if applicable): _____ Address: _____

**Insurance Information:** ☐ Insured (Please fill out the information below) ☐ Self-Pay (No insurance)

Insurance Company Name: _____ Member ID#: _____

Please include the 1-800 # for Provider/Member Services on back of insurance card: _____

Subscriber Name: _____ Effective Date: _____

Co-pay amount for specialist visit: _____

**Are you covered under any other insurance policy?** ☐ No ☐ Yes (Please fill out information below)

If yes, insurance name: _____ Member ID#: _____ Effective Date: _____