AFMC
American Fertility
Medical Center

AMERICAN FERTILITY MEDICAL CENTER

2 Hughes, Suite 175, Irvine, CA 92618

PATIENT'S INFORMATION

AFMC #: ______________________ (FOR OFFICE USE ONLY)

First Name: ____________________________ **MI:** ______________ **Last:** ______________________________
Birth Date: ____________________________________ **Age:** _________________ □ **Male** □ **Female**
Marital Status: □ **Single** □ **Married** □ **Divorced** □ **Widow** □ **Widower** □ **Domestic Partner**
Address: ____
City: _________________________ **State:** __________________________ **Zip:** __________________________
Home Phone Number: ________________________ **Cell Phone Number:** ________________________________
Email Address: ____
Driver's License Number: ____ **Expiration Date:** ________________
Social Security Number: ____ **Occupation:** ____________________
Work Phone Number: ____ **Employer:** ______________________
- Do we have permission to leave a message for you or your partner on your home, cell, alt, or work phone number?
□ **Yes** □ **No**
- Do we have permission to release medical information to your partner? □ **Yes**□ **No**
- May we email you or your partner's medical info, updates, and AFMC mailings to the above email address?
□ **Yes** □ **No**
Emergency Contact Person: _________________________ **Relationship to Pt.:** ___________________________
Phone number where they can be reached: ____

I certify that the information on this form is true and correct to the best of my knowledge, and that I will notify AFMC of any changes. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any services rendered.

Signature: ____ **Date:** __________________________________

PARTNER'S INFORMATION

AFMC #: ______________________ (FOR OFFICE USE ONLY

First Name: ____________________________ **MI:** ______________ **Last:** ______________________________
Birth Date: ____________________________________ **Age:** _________________ □ **Male** □ **Female**
Marital Status: □ **Single** □ **Married** □ **Divorced** □ **Widow** □ **Widower** □ **Domestic Partner**
Address: ____
City: _________________________ **State:** __________________________ **Zip:** __________________________
Home Phone Number: ________________________ **Cell Phone Number:** ________________________________
Email______________________________**Address:** ____
Driver's License Number: ____ **Expiration Date:** ________________
Social Security Number: ____ **Occupation:** ____________________
Work Phone Number: ____ **Employer:** ______________________
- Do we have permission to leave a message for you or your partner on your home, cell, alt, or work phone number?
□ **Yes** □ **No**
- Do we have permission to release medical information to your partner? □ **Yes**□ **No**
- May we email you or your partner's medical info, updates, and AFMC mailings to the above email address?
□ **Yes** □ **No**
Emergency Contact Person: _________________________ **Relationship to Pt.:** ___________________________
Phone number where they can be reached: ____

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Signature: ____ **Date:** __________________________________