Fertility & Surgical
ASSOCIATES OF CALIFORNIA

www.fertilityassociates.com

PATIENT'S INFORMATION **FSAC #:** _____ (FOR OFFICE USE ONLY) **TRI-COUNTY SURGERY CENTER #:** _____ (FOR OFFICE USE ONLY)

First Name: _____ **MI:** _____ **Last:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone Number: _____ **Birth Date:** _____ **Age:** _____

Cell Phone Number: _____ **Alternative Phone Number:** _____ **Biological Sex:** □ **M** □ **F** □**Intersex**_____

Drivers License Number: _____ **Expiration Date:** _____

Social Security Number: _____ **Marital Status:** □ **Single** □ **Married** □ **Divorced**

Occupation: _____ □ **Widow** □ **Widower** □ **Domestic Partner**

Employer: _____ **Work Phone Number:** _____

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** **Preferred Pronouns:** _____

Email Address: _____ **Gender:** □ **Male** □ **Female** □ **Other**_____

May we email you or your partner's medical info, updates, and FSAC mailings to the above email address? □ **Yes** □ **No**

Emergency Contact Person: _____ **Relationship to Pt.:** _____

Phone number where they can be reached: _____

How did you hear about us?:_____

I certify that the information on this form is true and correct to the best of my knowledge, and that I will notify FSAC 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 **FSAC #:** _____ (FOR OFFICE USE ONLY) **TRI-COUNTY SURGERY CENTER #:** _____ (FOR OFFICE USE ONLY)

First Name: _____ **MI:** _____ **Last:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone Number: _____ **Birth Date:** _____ **Age:** _____

Cell Phone Number: _____ **Alternative Phone Number:** _____ **Biological Sex:** □ **M** □ **F** □**Intersex**_____

Drivers License Number: _____ **Expiration Date:** _____

Social Security Number: _____ **Marital Status:** □ **Single** □ **Married** □ **Divorced**

Occupation: _____ □ **Widow** □ **Widower** □ **Domestic Partner**

Employer: _____ **Work Phone Number:** _____

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** **Preferred Pronouns:** _____

Email Address: _____ **Gender:** □ **Male** □ **Female** □ **Other**_____

May we email you or your partner's medical info, updates, and FSAC 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:** _____