Male Fertility and Sexual Medicine Specialists

MARTIN BASTUBA, M.D., F.A.C.S.

NEW PATIENT PERSONAL INFORMATION

Patient Name: **LAST** **FIRST** **M.I.**			**Date:**
Social Security #		**Date of Birth**	
Home #	**Work #**		**Cell Phone #**
Address		**Email Address to receive our newsletter**	
City, State, Zip Code			
Employer			**Occupation**
Circle All That Apply: **Male** **Female** **Minor** **Single** **Married** **Divorced** **Widowed** **Separated**			
Spouse's Name:		**Referred By** (first & last name):	
Where have you heard our name (Internet, TV, friend, doctor):		**What made you decide to come to us** (MD/friend's recommendation, web site info)	
RESPONSIBLE PARTY: Who is responsible for the account? (If other than the patient) **Name: Last** **First**			
Relationship to the patient:			
Social Security #		**Date of Birth**	
Address			
City, State, Zip Code			
Employer			**Occupation**
Home #	**Work #**		**Cell #**
Where do you prefer to receive calls? (circle one) **Home** **Work** **Cell**			**Is it okay to leave a message?** **Yes** **No**
What is the best time to reach you?		**Days?**	
In the case of an emergency whom should we contact? (Not living with you) **LAST** **FIRST**			
Relationship	**Home #**	**Work #**	**Cell #**
INSURANCE INFORMATION			
Name of Insured: **Last** **First** **M.I.**		**Insured Birth Date:**	
Relationship to Patient		**Soc. Sec. #**	
Employer:	**Occupation**		**Date Employed**
Insurance Company and Address			
Group #	**Employee/Cert. #**		
Deductible	**Amount Already Used**		
Additional Insurance			
Name of Insured	**Relationship**	**Soc. Sec.#**	**Insured Birth Date**

Authorization and Release:

I authorize this release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf and my dependants. I realize that failure to keep this account current may result in you being unable to provide additional services. In the case of default on payment of this account, I agree to pay a processing fee and reasonable attorney fees incurred to collect on this amount any further outstanding balances.

Signature of Patient or parent if patient is a Minor_____Date_____