❑ Thomas Vaughn, M.D. ❑Kaylen Silverberg, M.D. ❑Lisa Hansard, M.D. ❑ Natalie Burger, M.D.
❑Anthony Propst, M.D. ❑Erika Munch, M.D. ❑Susan Hudson, M.D.

PATIENT INFORMATION

Last Name	First Name	MI

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former or other name:

Address	City	State	Zip

Date of Birth	Social Security No.	Driver's License No.	Marital Status ○ Single ○ Married ○ Divorced ○ Widowed

Home Phone ( )	Work Phone ( )	Cell Phone ( )	E-Mail (separate consent required)

Referring Source ❑Advertisement ❑Website ❑Friend ❑Physician _____ ❑Other_____

PCP/OBGYN Name:_____

Employer Name	Occupation

Employer Address	City	State	Zip

PARTNER INFORMATION

Name of Spouse/Partner	Driver's License No.	Date of Birth	Social Security No.

Is this your legal name: ○ Yes ○ No	If not, what is your legal name?	Former or other name?

Occupation	Employer Name	Work Phone ( )	Phone Number ( )

EMERGENCY CONTACT

Name	Relationship	Phone Number ( )

Address	City	State	Zip

Assignment/Authorization of Benefits: I hereby give authorization for payment of insurance benefits to be made directly to *Texas Fertility Center* for services rendered, and authorize this healthcare provider to release all information necessary to secure payment. I understand that I am financially responsible for all charges whether they are covered by insurance. I further agree that this assignment/authorization of benefits will remain in effect until revoked by me in writing, and that a photocopy of this agreement is as valid as the original. By providing the above information, I have consented to be contacted by Texas Fertility Center at any of the above addresses or telephone numbers.

Patient Signature_____Date_____

Partner Signature_____Date_____