PALM BEACH FERTILITY CENTER
MARK DENKER, M.D.

Female Patient Registration

Last Name _____ First Name _____ MI _____

Age _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Date of Birth _____ Email _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Is it ok to leave a message? ☐ Yes ☐ No

Cell Phone _____ Is it ok to leave a message? ☐ Yes ☐ No

Work Phone _____ Is it ok to leave a message? ☐ Yes ☐ No

Occupation _____ Employer Name _____

Emergency Contact (other than spouse)

Name & Address _____

Phone _____ Relationship to patient _____

Referred By

☐ Friend (Name _____) ☐ Physician (Name _____)

☐ Insurance ☐ Seminar ☐ Web site ☐ Other: _____

Preferred OB/GYN physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Partner

Last Name _____ First Name _____ MI _____

Age _____ Date of Birth _____

Occupation _____ Employer Name _____

Work Phone _____ Cell Phone _____

Insurance Information

Insurance Company _____ ID# _____

Insurance Type: (choose one)

☐ PPO ☐ HMO ☐ POS ☐ EPO ☐ EPP

Customer Service Phone # _____ Group Number _____ Plan Number _____

Claims Mailing Address _____

Primary Card Holder Name _____Relationship _____Date of Birth _____

Consent to Treat

While I am here, I permit the employees, the physician, and other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending physician will explain to me the nature of my condition and his recommended treatment and any associated risk involved. I also understand that he will explain to me other ways this condition could be treated. I further understand that this care may include tests, examinations, medical and/or surgical treatment. No guarantees have been made to me about the outcome of this care.

Assignment of Benefits

I authorize **MARK DENKER, M.D., PA**, to release to the insurance carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim be made directly to **MARK DENKER, M.D., PA.**

Financial Agreement

I understand that that I am financially responsible for all services received regardless of insurance payment or denial. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I understand that if I fail to obtain an authorization from my Primary Care Physician, where applicable, that I am solely responsible for payment of all charges. There is a $25 service charge on any returned checks.

Patient Signature _____Date _____