



**ADVANCED REPRODUCTIVE  
MEDICINE & GYNECOLOGY**

407 Uluniu Street Suite 312  
Kailua HI 96734  
808-262-0544



**FERTILITY INSTITUTE  
OF HAWAII**

1401 S. Beretania Street Suite 250  
Honolulu HI 96814  
(808) 545-2800

Date \_\_\_\_\_

Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_ Unit# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_) \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse/Partner Name: \_\_\_\_\_ Spouse/Partner DOB: \_\_\_\_\_

*In case of an emergency, we have your permission to contact:*

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

**RACE: Check ONE of the Following**

American Indian or Alaska Native  Asian  Native Hawaiian  Black or African American  White

Hispanic  Other Race  Other Pacific Islander  Refuse to report

**ETHNICITY: Check ONE of the following**

Hispanic or Latin  Not Hispanic or Latin  Refuse to report

**PRIMARY LANGUAGE:** \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referred by Primary care physician? Yes / No

How did you hear about our office? \_\_\_\_\_

GUARANTOR INFORMATION (person in charge of account if different from patient):

Guarantor Legal Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Address: \_\_\_\_\_ Unit# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Employer Name \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Patient's Relationship to Guarantor: Spouse \_\_\_\_\_ Child \_\_\_\_\_ Legal Guardian \_\_\_\_\_ Other \_\_\_\_\_

INSURANCE INFORMATION

Primary Insurance Company \_\_\_\_\_ Subscriber # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_ Relationship \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Subscriber # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_ Relationship \_\_\_\_\_



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If we need to contact you regarding any future appointments or test results may we leave a message? **Yes or No** (please circle)

Phone number you prefer us to call: \_\_\_\_\_

INITIAL: \_\_\_\_\_

Would you like us to e-mail you patient education handouts rather than give you hard copies? **Yes or No** (please circle)

E-mail address: \_\_\_\_\_

INITIAL: \_\_\_\_\_

**CONSENT FOR TREATMENT**

I, the undersigned, voluntarily agree to tests, procedures, and/or treatments, which the physician and I have discussed and deemed necessary.

INITIAL: \_\_\_\_\_

**PAYMENT TERMS AND AGREEMENTS**

I, the undersigned, in consideration for services rendered to the patient by Advanced Reproductive Medicine and Gynecology of Hawaii, Inc., understand and agree to the following:

1. I understand that payment for charges is due on the date of service with the exception of insurance carriers for which we are under contract to file directly.
2. I understand that my insurance coverage may not provide payment for all charges incurred in obtaining treatment. I will be responsible for any co-payment, deductible or service not covered by my insurance provider. If I do not have insurance coverage for services rendered, I agree to pay all charges resulting from such services.
3. I hereby authorize Advanced Reproductive Medicine and Gynecology of Hawaii, Inc. to file with my insurance carrier and I assign payment of medical benefits to Advanced Reproductive Medicine and Gynecology of Hawaii, Inc.
4. I authorize release of any and all medical records and information necessary to process any claim generated by services I received in this office.

INITIAL: \_\_\_\_\_

**My signature below indicates that I have read, understand and agree to all terms set above:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_