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:_____