

Southern California Center for Reproductive Medicine

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PATIENT INFORMATION

PATIENT/WIFE:

Last Name: _____ First: _____ Initial: _____

Last Name on Insurance Plan, if different from above: _____

Home Address: _____

City _____ State: _____ Zip Code: _____

Mailing Address (if different from above): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Emergency Phone: _____ Relationship: _____

Social Security #: _____ (necessary for medical insurance claims)

Driver's License #: _____ Date of Birth: _____ Age: _____

Employer/Occupation: _____

Marital Status: Married Divorced Separated Single Other

HUSBAND/PARTNER:

Last Name: _____ First: _____ Initial: _____

Spouse's Social Security #: _____ Date of Birth: _____

Spouse's Employer: _____ Work Phone: _____

PATIENT REFERRED TO THIS OFFICE BY:

Dr. _____ Patient/Friend: _____

SCCRM Website Insurance Co: _____

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE PLAN: _____

Name of Policy Holder: _____

Relationship to Patient: **Self** **Spouse** **Other:** _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group Name or Number: _____

Subscriber ID # _____ **Policy #** _____

Insured's Employer: _____ **Phone #** _____

Address: _____

If the policy is under the patient/wife's name, is the spouse/partner covered on the plan?

Yes No

Does this insurance company cover the following:

Diagnosis of Infertility Only

Diagnosis & Treatment of Infertility

Treatment to Achieve Pregnancy

No Infertility Coverage

SECONDARY INS. PLAN (Spouse or Partner's): _____
(Even if you are not on the plan)

Subscriber's Name: _____

Relationship to Patient: **Spouse** **Other:** _____

Insurance Co. Address: _____

Insurance Co. Phone # _____

Group Name or Number: _____

Subscriber ID # _____ **Policy #** _____

Insured's Employer: _____ **Phone #** _____

Address: _____

If the policy is under the patient/wife's name, is the spouse/partner covered on the plan?

Yes No

Does this insurance company cover the following:

Diagnosis of Infertility Only

Diagnosis & Treatment of Infertility

Treatment to Achieve Pregnancy

No Infertility Coverage

Please indicate which Laboratories are contracted with your insurance company:

Westcliff Medical Laboratory	-	Patient	Spouse/Partner
UniLab	-	Patient	Spouse/Partner
Lab Corp	-	Patient	Spouse/Partner
Bristol Park Laboratory Only	-	Patient	Spouse/Partner
Other: _____	-	Patient	Spouse/Partner

Please indicate which Hospitals are contracted with your insurance company:

Hoag Memorial Hospital Presbyterian	-	Patient	Spouse/Partner
Irvine Medical Center	-	Patient	Spouse/Partner
Mission Hospital	-	Patient	Spouse/Partner
Newport Beach Surgery Center (out-patient facility)	-	Patient	Spouse/Partner
Other: _____	-	Patient	Spouse/Partner

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits to be paid directly to: Robert E. Anderson, M.D.

I am financially responsible for non-covered services. I also authorize the physicians to release any information required to process my medical claims.

Patient

Signature: _____ Date: _____

Spouse/Partner

Signature: _____ Date: _____