

Colorado Reproductive Endocrinology

4600 E. Hale Parkway, Suite 350
Denver, CO 80220
303-321-7115

MALE PATIENT INFORMATION

Date: _____

First Name M.I. Last Name Home Phone: _____

Street Address City/State/Zip Code

Social Security No: ____ / ____ / ____ Date of Birth: ____ / ____ / ____

Employer: _____ Work Phone: _____

Spouse/Partner Name: _____ **Is Spouse/Partner a patient here? Y/N**

Primary Care Physician: _____

Insurance Information:

Patient's Primary Insurance

Patient's Secondary Insurance

Policy Holder: _____

Policy Holder: _____

Group#: _____

Group#: _____

ID#: _____

ID#: _____

Insurance Company Address:

Insurance Company Address:

Insurance Company Phone Number:

Insurance Company Phone Number:

I am aware that I may inquire of my health provider the fee(s) for the professional services required and/or rendered. I authorize payment of all medical benefits to the assigned physician for these services and all future claims. I also authorize Colorado Reproductive Endocrinology to release any medical information to process this claim and any future claims.

Patient Signature: _____

I further authorize Colorado Reproductive Endocrinology to release results of any test to my spouse/partner. **YES or NO**

Patient Signature: _____