Noble Fertility Center
Making Your Dreams Into Precious Gifts

PATIENT REGISTRATION FORM 病人登记表

DATE日期: ______________________________ ACCOUNT# 编号: ________________________________

Name 姓名:	
Address地址:	SS# 社安号:
City城市:	Gender性别: □ M 男 □ F 女
State州: ZIP邮编:	D.O.B. 出生日期:
Home Phone住家电话:	AGE年龄:
Work Phone工作电话:	Marital Status婚姻状况: □ Single单身 □ Married已婚
Cell手机:	Ethnic Background种族: □ Asian亚裔 □ Other其他
Employer雇主:	
Work Address工作地址:	**REFERRED BY介绍人**:
City城市:	Address地址:
State州: ZIP邮编:	City城市:
Occupation职位:	State州: ZIP邮编:
Partner's Information配偶资料:	Name姓名:
Home Phone住家电话:	SS# 社安号:
Work Phone工作电话:	D.O.B. 出生年月:
Occupation职业:	Ethnic Background种族: □ Asian亚裔 □ Other其他
Primary Insurance第一保险:	Insured's Name受保人姓名:
Address地址:	
	Insured's DOB受保人出生日期:
Phone#电话:	Insured's Gender受保人性别: □ M 男 □ F 女
Policy#保险卡号:	Patient Relationship to Insured病人与受保人关系:
Group#团体号:	□ Self本人 □ Spouse配偶 □ Other其他
Policy Effective Day保险卡生效日期:	Insured's Employer受保人雇主:
Secondary Insurance第二保险:	Insured's Name受保人姓名:
Address地址:	
	Insured's DOB受保人出生日期:
Phone#电话:	Insured's Gender受保人性别: □ M 男 □ F 女
Policy#保险卡号:	Patient Relationship to Insured病人与受保人关系:
Group#团体号:	□ Self本人 □ Spouse配偶 □ Other其他
Policy Effective Day保险卡生效日期:	Insured's Employer受保人雇主:
Emergency Contact-Phone紧急联系人姓名与电话:	**Pharmacy Name-Phone药房名字与电话:**

I authorize payment of medical benefits to physicians or suppliers for services rendered. I authorize the release of any medical information necessary to process these claims. I also understand that it takes Beth Israel 3-4 months to process any refunds.

PATIENT SIGNATURE病人签名 ____________________ **DATE 日期** ____________________