FERTILITY CENTER OF ORLANDO

Milton McNichol, MD

Demographic History and Authorization Form

Name _____ Today's date _____/_____/____
LAST FIRST MIDDLE

Address_____

City _____ Cell No. (_____) _____
City State Zip

SS# _____ Date of birth _____/_____/_____ Age_____

Home Phone No. (_____)_____ Email _____

Your Employer _____Tel. No. _____

Employer's Address _____

Partner's Name _____ DOB _____/_____/_____

Partner's SS# _____ Partner's Cell Phone No. (_____)_____

Partner's Employer_____ Tel.No. _____

Who may we thank for referring you to our practice? _____

MEDICAL INSURANCE INFORMATION

Primary Ins: _____ Insurance Company Name _____
Subscriber's Name

ID No. _____ Group No. _____

Secondary Ins: Subscriber Name_____ Ins Name_____

ID No. _____ Group No. _____

ASSIGNMENT OF BENEFIT:

I hereby assign payment of all medical and/or surgical insurance benefits to which I am entitled, including payment by government sponsored programs, private insurance, and any other health plans, to **Dr. Milton McNichol and FERTILITY CENTER OF ORLANDO (FCO).** I understand that I am financially responsible for all charges incurred as part of my treatment, until such charges are paid by my insurance carrier, FERTILITY CENTER OF ORLANDO will submit bills on my behalf to my Medical Insurance provider, for reimbursement, however I will remain responsible for full payment until FCO is reimbursed by my insurer. I also authorize FERTILITY CENTER OF ORLANDO TO release all information necessary to secure payment from my insurer. I understand that if my Medical insurer does not provide coverage for infertility services, payment will be required at the time of service. This assignment of benefits will remain in effect until revoked by me in writing. A photocopy or electronic copy of this assignment will be considered as valid as the original.

Signature_____ Date _____

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