



Reproductive Medicine Associates
of New Jersey

IVI RMA Global

DEMOGRAPHIC FORM

PATIENT'S NAME: _____ Appt Date/Dr: _____
 Home Address: _____ City: _____
 State: _____ Zip: _____
 Home Tel: _____ Work Tel: _____ ext: _____ Cell: _____
 Birth Date: _____ Sex: _____ Gender Identity: Female Male Social Security # _____
 Employer: _____ Occupation _____
 Email address: _____ Pharmacy Name and # _____
 Legal relationship status: Single Married Divorced Widowed Are you or your partner married to someone else? YES NO
 OB/GYN: _____ Tel # _____
 Did your OB/GYN refer you to our office YES NO if not how did you hear about us? _____
 Partner's Name: _____ Partner's Birth Date: _____ Social Security# _____
 Telephone # _____ Employer _____ Occupation _____
 Address (If different than yours): _____ Pharmacy# _____
 Home Tel: _____ Work Tel: _____ ext: _____ Cell: _____
 Email address: _____ Current Urologist: _____ Tel # _____

PATIENT'S INSURANCE CARRIER

Insurance Co: _____
 Address: _____
 Tel #: _____
 ID #: _____
 Group # _____ Spec Copay \$ _____
 Subscriber: _____
 Participating Lab: _____
 (LabCorp, Quest, etc.)

SPOUSE/PARTNER INSURANCE CARRIER

Insurance Co: _____
 Address: _____
 Tel #: _____
 ID #: _____
 Group # _____ Spec Copay \$ _____
 Subscriber: _____
 Participating Lab: _____
 (LabCorp, Quest, etc.)

Are you covered under your spouse/partner's insurance plan? YES NO

***Please note that male partners must also abide by the rules set forth by their insurance. If their plans require referrals or authorizations, they must be obtained prior to services being rendered. Male partners are not covered under referrals or authorizations issued for females.

Signature: _____ Date: _____

Authorizations: I authorize RMA of NJ physicians to release any information in the course of my examination or treatment to my insurance company. I further authorize any benefits due for services rendered to be paid directly to RMA of NJ. I understand that I am responsible for any charges not covered by my insurance and for any balance due after insurance payments. If RMA does not participate with my insurance company I also understand that payment MUST BE MADE AT THE TIME services are rendered. Please have a valid driver's license and insurance card ready for photocopy.

Signature: _____ Date: _____