



**FEMALE  
PATIENT**

THE FERTILITY  
*Wellness Institute*  
OF OHIO

NeeOo W. Chin, M.D.  
*Subspecialty Board Certified*

**PATIENT REGISTRATION FORM**

Date: \_\_\_\_\_ Referred By (Name & Phone): \_\_\_\_\_

**Patient Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First) (Middle)

SS#: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer Address: \_\_\_\_\_ Race: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Relation: \_\_\_\_\_

**Insurance Information**

Primary Insurance Co. Name: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

SS#: \_\_\_\_\_ Policy Holder Birthday: \_\_\_\_\_ Insurance ID/Policy Number: \_\_\_\_\_

Group #: \_\_\_\_\_ Referral Required? Yes / No

Primary Insurance Co. Name: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

SS#: \_\_\_\_\_ Policy Holder Birthday: \_\_\_\_\_ Insurance ID/Policy Number: \_\_\_\_\_

Group #: \_\_\_\_\_ Referral Required? Yes / No

\*\*\* I hereby authorize Dr. NeeOo W. Chin to release information to insurance carriers regarding my \*\*\*  
diagnosis and treatment and assign to the physician all reimbursement for medical services rendered.

I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY INSURANCE.

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**