



Mark P. Trolice, M.D., FACOG, FACS
Board Certified in Reproductive Endocrinology and Infertility

MALE AND/OR PARTNER INFORMATION FORM

Name: Last _____ First _____ MI _____
Address _____
City _____ State _____ County _____ Zip code _____
Home # (_____) _____ Cell # (_____) _____
Date of Birth _____ Pharmacy# (_____) _____
Social Security # _____
Email: _____

Marital Status: (Please check one) Single Married Divorced Widowed Remarried

Spouse/Partner Name: _____ Phone #: _____ DOB: _____

May we leave voice messages pertaining to your treatment?

No, I prefer to speak to a nurse.

Yes, I prefer my: Cell Home

Do we have permission to discuss your medical care with your partner? Yes No

EMPLOYER:

Employment Status: (Please check one) Full-time Part-time Self-employed Retired

Student Unemployed Homemaker

Employer's Name _____

Address _____

City _____ State _____ County _____ Zip code _____

Occupation _____ PHONE# _____

NEXT OF KIN:

Name _____ Relationship to Patient _____

Address _____

City _____ State _____ County _____ Zip code _____

Home # (_____) _____ Work # (_____) _____

EMERGENCY CONTACT: (DO NOT USE THE SAME PERSON AS NEXT OF KIN)

Name _____ Relationship to Patient _____

Address _____

City _____ State _____ County _____ Zip code _____

Home # (_____) _____ Work # (_____) _____

INSURANCE INFORMATION: *

Insured Name _____ Social Security # _____

Primary Insurance Company _____

Policy # _____ Group # _____

Address _____

City _____ State _____ County _____ Zip code _____

Phone # () _____

IF YOU ARE A PARTICIPANT OF AN INSURANCE COMPANY THAT REQUIRES PRE-AUTHORIZATION TO SEE A PHYSICIAN OTHER THEN YOUR PRIMARY CARE PHYSICIAN, **PLEASE CALL FOR YOUR REFERRAL NUMBER PRIOR TO YOUR APPOINTMENT.**

Referral # _____

*If you have additional insurance, please let us know.

Who may we thank for referring you to Fertility C.A.R.E.? _____

Address _____

City _____ State _____ County _____ Zip code _____

In signing, you acknowledge that verification of insurance is not a guarantee of payment from the insurance company and you understand that any service considered "Non-Covered" is your responsibility and you will be billed for such services. If there is no insurance available, you understand that you are expected to pay for any and all charges at the time services are rendered.

Patient Signature

Date