COLUMBIA FERTILITY ASSOCIATES

Columbia Fertility Associates

Patient Registration Form

Today's Date: _____ **Provider Scheduled With:** _____

Patient's Legal Name:

_____

Last **First** **MI**

Name you wish to be called:

Pronoun used: ☐She/her ☐He/him ☐They/them ☐_____

Date of Birth: _____ **Age:**_____ **SS#:** _____

Home Address: _____

Apt/Unit #: _____

City/State/Zip: _____

Sex (assigned at birth): ☐Female ☐Male ☐Intersex

Words Describing Your Gender (select all that apply): ☐Female ☐Male ☐Nonbinary ☐Cisgender ☐Transgender ☐Agender ☐_____

Occupation: _____

Employer: _____

Language: _____

Race: _____ **Ethnicity:** _____

☐Single ☐Married ☐Partnered (Unmarried) ☐Divorced ☐Widowed ☐Separated

Sexual Orientation: ☐Queer ☐Lesbian ☐Bisexual ☐Gay ☐Heterosexual ☐Pansexual ☐_____

Patient Contact Information	Call Order	OK to Contact	OK to Leave Detailed Message
Cell Phone:		☐Yes ☐No	☐Yes ☐No
Work Phone:		☐Yes ☐No	☐Yes ☐No
Home Phone:		☐Yes ☐No	☐Yes ☐No
Email Address:			**OK to email medical results:** ☐Yes ☐No

Spouse/Partner's Name: _____

Name they wish to be called: _____

Pronoun used: ☐She/her ☐He/him ☐They/them ☐_____

Date of Birth: _____ **Age:** _____ **SS#:** _____

Occupation: _____

Employer: _____

Sex (assigned at birth): ☐Female ☐Male ☐Intersex

Words Describing Their Gender: ☐Female ☐Male ☐Nonbinary ☐Cisgender ☐Transgender ☐Agender ☐_____

Cell phone: _____

Work phone: _____

Emergency Contact Information	Preferred Pharmacy Name:
Name: **Relationship:**	**Phone:** **FAX:**
Phone:	**Address:**

Primary Insurance Carrier:	Secondary Insurance Carrier:
Insurance Address:	Insurance Address:
Insurance Address:	Insurance Address:
Subscriber Name: DOB	**Subscriber Name: DOB**
Relationship to the subscriber: ☐Self ☐Spouse ☐Partner ☐ Child	Relationship to the subscriber: ☐Self ☐Spouse ☐Partner ☐ Child
Identification Number:	Identification Number:
Group Number:	Group Number:
Specialist Co-Pay: $	Specialist Co-Pay: $

WHO DO WE THANK FOR REFERRING YOU? (Please check all that apply)

☐Provider* ☐Patient _____

☐Friend/Relative ☐Social Media_____

☐Internet/Web Site ☐Radio_____

☐Washingtonian Top Doctors ☐Other_____

***Referring Provider Name:** _____

Specialty: _____

Address: _____

City/State/Zip: _____

Phone: _____ FAX: _____

I agree that the above information is correct as listed or changed as indicated. I authorize my insurance company to make payments directly to Columbia Fertility Associates, PLLC (CFA). I further authorize CFA to release any information about my medical care to my insurance company. This includes diagnosis, treatment and other information contained within the medical record. I agree to pay for any medical services that are not covered under my insurance, This includes all co-pays and co-insurance balance.

_____ _____

Patient/Guardian Signature **Date**

For Office Use Only

Account updated by: _____(Initials) Date:_____

Form Revised 05/25/2025 smo