Dr. Deborah L. Smith **Colorado Reproductive Endocrinology** **Dr. Susan Trout**
4600 E. Hale Parkway, Suite 350
Denver, CO 80220
303-321-7115

MALE PATIENT INFORMATION Date: _____

_____ _____ _____ Home Phone: _____
First Name M.I. Last Name

_____ _____
Street Address City/State/Zip Code

Social Security No: ____/____/____ Date of Birth: ____/____/____

Employer: _____ Work Phone: _____

Spouse/Partner Name: _____ **Is Spouse/Partner a patient here? Y/N**

Primary Care Physician: _____

Insurance Information:

Patient's Primary Insurance	Patient's Secondary Insurance
Policy Holder: _____	Policy Holder: _____
Group#: _____	Group#: _____
ID#: _____	ID#: _____
Insurance Company Address:	Insurance Company Address:
_____	_____
_____	_____
Insurance Company Phone Number:	Insurance Company Phone Number:
_____	_____

I am aware that I may inquire of my health provider the fee(s) for the professional services required and/or rendered. I authorize payment of all medical benefits to the assigned physician for these services and all future claims. I also authorize Colorado Reproductive Endocrinology to release any medical information to process this claim and any future claims.

Patient Signature: _____

I further authorize Colorado Reproductive Endocrinology to release results of any test to my spouse/partner. **YES or NO**

Patient Signature: _____