LANE fertility institute

PATIENT INFORMATION SHEET

Patient's Full Legal Name: _____

Partner's Full Legal Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Marital Status: _____

Email: _____ Insurance Carrier:_____

Patient Information: (Please provide us with a copy of your driver's license and insurance card)

Date of Birth: _____ Age: _____ SSN: _____

Occupation: _____

Employer: _____

Work Phone: ( ) _____ Cell Phone: ( )_____

Height: _____ Weight: _____ Allergies? _____

Preferred Pharmacy: _____

Partner's Information:

Date of Birth: _____ Age: _____ SSN: _____

Occupation: _____

Employer: _____

Work Phone: ( ) _____Cell Phone: ( ) _____

Physician: ☐ OB/GYN or ☐ Primary Care (if you don't have an OB/GYN)

Name: _____ Phone: ( ) _____

Address: _____

Emergency Contact:_____Phone: ( ) _____

I hereby authorize Dr. Danielle Lane to release medical records to myself, my insurance carrier and to my physician listed above.

Signature of patient _____ ***Date:*** _____