Sy Q Le, M.D.
Board Certified in Reproductive Endocrinology & Infertility

www.ivfmd.net

GENERAL INFORMATION

Name: _____ _____ _____
First (Nombre) Middle (Inicial) Last (Apellido)

Home Address: _____
Street (Direccion)

City _____ State _____ Zip _____
(Ciudad) (Estado) (Postal)

Telephone Home # _____ Work # _____ Cell # _____
(Casa #) (Trabajo #) (Cellular #)

Birthdate _____ Age _____ SSN # _____
(Fecha de Nacimiento) (Edad) (Seguro Social)

Marital Status ☐ Married ☐ Single ☐ Common Law Occupation _____
(Marital) (Ocupacion)

Employer _____ _____
(Empleador) Address (Direccion)

Insurance Name _____ Insurance ID # _____ Group # _____
(Aseguranza) (Numero de Poliza)

Responsible Party ☐ Self ☐ Spouse ☐ Other _____

Responsible Party's Name _____ Occupation _____

Responsible Party's Employer _____

Responsible Party Employer Address _____

Who referred you ? _____ Primary Care Physician _____
(Quien le recomendo esta oficiana?)

Emergency Contact Person _____ Phone # _____

INSURANCE AUTHORIZATION: I hereby authorize **IVFMD & Advanced Reproductive Laboratory (ARL)** to furnish information to my insurance carriers concerning my illness and treatment. I agree that if I fail to notify IVFMD & ARL of insurance change or obtain required referrals or preauthorization for services, I will be responsible for those charges.
AUTORIZACION DE SEGURO: Autorizo **IVFMD & Advanced Reproductive Laboratory** que provea informacion medica de mi persona a las companias de seguro necesarias. Convengo que si no notifico ARCC & ARL del cambio del seguro u obtener requirió remisiones o el preauthorization para los servicios, yo seré responsable de esas cargas.

ASSIGNMENT OF BENEFITS: I hereby assign **IVFMD & Advanced Reproductive Laboratory** all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.
AUTORIZACION DE BENEFICIOS: Asigno **IVFMD & Advanced Reproductive Laboratory** los beneficios del seguro, por servicios prestados a mi persona o dependientes mios. Entiendo que soy responsable por aquellos gastos no cubiertos por las companias de seguros.

_____ _____
Signature of Authorized Person (Firma de la Persona Autorizada) Date (Fecha)

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600 W Mayfield Rd Arlington, TX 76014 Tel 817-701-1290 Fax 817-701-1297