UC Center for Reproductive Health

The Christ Hospital Medical Office Building
2123 Auburn Ave., Suite A44
Cincinnati, OH 45219
PH: 513-585-2355 FX: 513-585-3098

UC Health Physicians Office
7700 University Court, Suite 3000
West Chester, OH 45069
PH: 513-585-2355 FX: 513-475-8267

Patient Demographics
(Please Fill Out Completely)

CONTACT INFORMATION

Home Phone _____ Work Phone _____ Cell Phone _____

Pharmacy Name and Number _____

May we release confidential information/test results to your partner: Yes / No

May we leave confidential messages on answering machines at: Home: Yes / No **Work:** Yes / No **Cell:** Yes / No

PATIENT'S INFORMATION

First Name _____ Middle _____ Last _____

Street _____ City _____ State _____ Zip _____

County: Hamilton Clermont Butler Warren Kenton Boone Campbell Other: _____

Maiden Name _____ Date of Birth _____ SS# _____ Race _____

Name you go by if other than above _____ Marital Status _____

Alternate Contact Name _____ Relationship to Patient _____

Street _____ City _____ State _____ Zip _____ Phone Number _____

Patient's Employer _____ Occupation _____

Street _____ City _____ State _____ Zip _____ Phone Number _____

Employment Status: Full-time Part-time Self-employed Not employed Active Military Retired

Primary Care Physician _____ Referring Physician _____

INSURANCE INFORMATION

Primary Ins. _____ Policy # _____ Group # _____ Eff. Date _____

Street _____ City _____ State _____ Zip _____ Phone Number _____

Secondary Ins. _____ Policy # _____ Group # _____ Eff. Date _____

Name of Policyholder _____ Relationship to patient _____

Patient's Signature _____ Date _____

UC Health

SPOUSE / PARENT INFORMATION:

First Name _____ Middle _____ Last _____

Street _____ City _____ State _____ Zip _____ Phone Number _____

Name you go by if other than above _____Date of Birth _____ SS# _____

Marital Status _____ Religion _____ Primary Care Physician _____

Employer _____ Occupation _____

Street _____ City _____ State _____ Zip _____ Phone Number _____

Occupation _____ Status of Employment _____

Spouse's Signature (if infertility visit)_____ **Date** _____

SPOUSE / PARENT INSURANCE INFORMATION:

Primary Ins. _____ Policy # _____ Group # _____ Eff. Date _____

Street _____ City _____ State _____ Zip _____ Phone Number_____

Secondary Ins. _____ Policy # _____ Group # _____ Eff. Date _____

Name of Policyholder_____ Relationship to patient_____