

**The Center For Reproductive Medicine, P.C.**  
**George T. Koullanos, M.D.**  
**George B. Inge, M.D.**

Three Mobile Infirmiry Circle • Suite 213  
Mobile, Alabama 36607  
(251) 438-4200 • (251) 438-4211

Date \_\_\_\_\_ Email Address \_\_\_\_\_ Chart No. \_\_\_\_\_

Patients Name \_\_\_\_\_  
First Middle Last

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Patient's** Social Security No. \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Business Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Circle One: *Single Married Widowed Divorced* Age \_\_\_\_\_ Birth Date \_\_\_\_\_

**Patient's** Employer/School \_\_\_\_\_

Business Address \_\_\_\_\_

Occupation \_\_\_\_\_ **Full Time** \_\_\_\_\_ **Part Time** \_\_\_\_\_

**Spouse's/Partner Name** \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Cell Phone \_\_\_\_\_

Birth Date \_\_\_\_\_ **Social Security No.** \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_

Subscriber Self or Spouse (please circle one) Group No. \_\_\_\_\_

**Insurance Information**

Primary Insurance \_\_\_\_\_

Contract No. \_\_\_\_\_

Group No. \_\_\_\_\_

Subscriber Self or Spouse (please circle one)

Secondary Insurance \_\_\_\_\_

Contract No. \_\_\_\_\_

Group No. \_\_\_\_\_

Subscriber Self or Spouse (please circle one)

**Pharmacy Name** \_\_\_\_\_

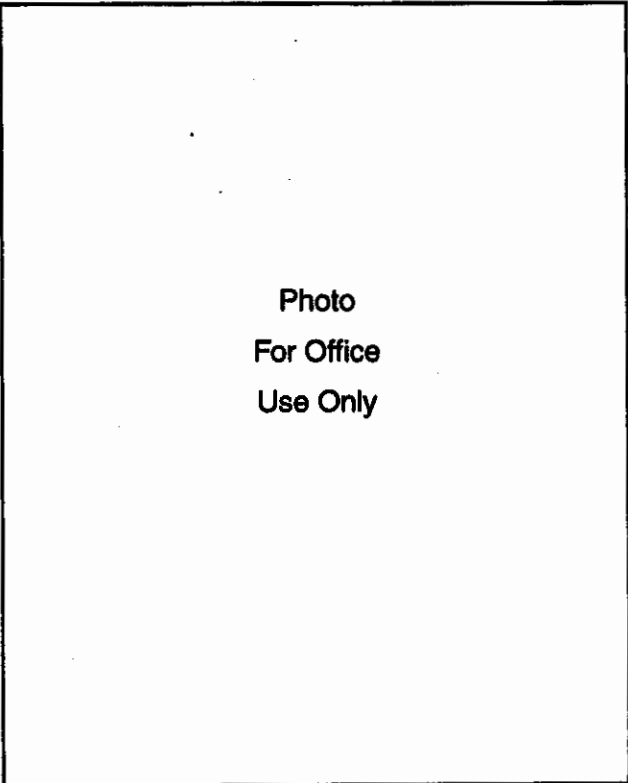
Phone \_\_\_\_\_

**In case of emergency, contact (other than spouse):**

\_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Relationship \_\_\_\_\_



**We accept assignment on most insurance carrier's but *YOU* are responsible for any services not covered by your insurance carrier. *YOU* are responsible for all charges incurred. You are responsible for any medical fees which your insurance companies denies for failure on your part to obtain referrals or prior authorizations. You are responsible for services rendered which are not paid for by your insurance at the time of service such as deductibles, co-pays and for services which are deemed necessary by our physicians, but are not covered by your insurance even if your insurance carrier deems the service not necessary. In the event you fail to pay for services rendered, you agree to pay reasonable attorney's fees and all costs of collection including court costs if this matter is referred to an attorney.**

**Medical Records Release and Assignment either by Fax or Copies**

**I hereby authorize my physician Dr. George T. Koullanos or Dr. George B Inge to release any information acquired in the course of my examination or treatment by Dr. Koullanos or Dr. Inge to my health insurance carriers, referring physicians, and any other physicians or hospitals which might provide services to me while I am receiving services from Dr. George T. Koullanos or Dr. George B. Inge. I understand that this information is either transmitted through FAX transmission or copies made of the original document mailed via US Post Master.**

**I have read the above agreement, and understand that I am responsible for the charges incurred.**

\_\_\_\_\_ **Date** \_\_\_\_\_  
**Signature**

\_\_\_\_\_

**How did you learn of our practice?** \_\_\_\_\_

**Referring Doctor:** \_\_\_\_\_