SPRING FERTILITY

Know your options.

newpatientsny@springfertility.com
p. (646) 568-5638
f. (646) 568-5637

New York Clinic / Lab

114 W 41st St., 2nd Floor
New York, NY 10036

Note To Patient: *Please bring your ID and insurance information. Note that payment will be due at time of service.*

Patient Name _____

Email _____

Phone _____ **D.O.B.** _____

If Applicable:

Partner Name _____

Partner Email _____

Partner Phone _____ **Partner D.O.B.** _____

CONSULTATION (choose one):

- ☐ Infertility Consult
- ☐ Fertility Preservation
- ☐ LGBTQ+
- ☐ Single Parent by Choice
- ☐ Fertility Wellness Counseling
- ☐ Genetic Counselor

SPECIFIC SERVICES:

- ☐ HSG
- ☐ Semen Analysis (Strict Morphology)
- ☐ Semen Analysis (Routine)
- ☐ IUI Wash

COMMENTS:

Referring Physician _____

Physician Signature _____

Office Phone _____

All results sent via fax.

Fax Number _____

SEND IN EMAIL

NOTE: PLEASE BE SURE COMPLETED PDF IS ATTACHED BEFORE SENDING