

**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. \_\_\_\_\_

#### CONSULTATION (choose one):

- |  |  |
|--|--|
| <input type="checkbox"/> Infertility Consult                   | <input type="checkbox"/> Fertility Preservation  |
| <input type="checkbox"/> LGBTQ+                                | <input type="checkbox"/> Single Parent by Choice |
| <input type="checkbox"/> Reproductive Mental Health Counseling | <input type="checkbox"/> Genetic Counselor       |

Referring Physician \_\_\_\_\_

Physician Signature \_\_\_\_\_

Office Phone \_\_\_\_\_

*All results sent via fax.*

Office Fax Number \_\_\_\_\_

#### COMMENTS:

**Know your options.**