

**Kutteh Ke Fertility Associates of Memphis, PLLC**  
 80 Humphreys Center, Suite 307  
 Memphis, TN 38120-2363  
 (901) 747-BABY (901) 747-2229 Fax (901) 747-4446  
 www.fertilitymemphis.com

**Registration Form**

PATIENT INFORMATION		
NAME (Last, First, Middle Initial)	Date of Birth / /	Social Security Number -
Address City	State/Zip	Home Phone ( )
Employer	Occupation/Department	Cell Phone ( )
Employment Address City	State/Zip	Work Phone ( )
Referring Physician	Address City	State/Zip
How did you hear about our practice?		
SPOUSE	INFORMATION	
NAME (Last, First, Middle Initial)	Date of Birth / /	Social Security Number -
Address City	State/Zip	Spouse Phone ( )
Spouse Employer	Occupation/Department	Work Phone ( )
Employer Address City	State/Zip	
INSURANCE INFORMATION		
Provider Name	Expiration Date	Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insurance Company	Address City State/Zip	
Insured Name	Group No., Policy No., I.D. No., Effective Date	
Secondary Insurance Co.		Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Address	City State/Zip	
Insured Name	Group No., Policy No., I.D. No., Effective Date	

**PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST FOR PHOTOCOPYING**

PATIENT'S RESPONSIBILITIES: I understand that as the patient, parent, or guardian, I am legally responsible for payment of all charges relating to my care. Patient and/or guarantor(s) agree to pay reasonable attorney's fees and cost of

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment is correct. I authorize any holder of medical or other information about me to release to the insurance company or its representatives, any information needed for this or other insurance claim. In consideration of services rendered, I transfer and assign to Kutteh Ke Fertility Associates of Memphis, PLLC, any payment which may become due to me for medical and/or surgical services under policies applicable to me or my dependent.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Guarantor Signature

\_\_\_\_\_  
Witness Signature