THECENTER FOR REPRODUCTIVE HEALTH
508 W Sixth Avenue, Suite 500, Spokane, WA 99204 (509) 462-7070 or (800) 334-1409
Edwin D. Robins, MD; Debbie Little, ARNP

MALE PATIENT INFORMATION

(Legal) Name: _____ Date of Birth: _____
(First) (Middle) (Last)

Address:
_____
(Street) (City) (State) (Zip Code)

Home phone: (_____)_____ Social Security #: _____

Cell phone: (_____)_____ E-Mail Address: _____

Patient employer: _____ Occupation: _____

May we contact you at work? Yes No Work Phone #: _____

Emergency Contact: _____ Phone # _____

REFERRAL INFORMATION

OB/GYN Physician: _____ Phone #: _____

Did your OB/GYN refer you to our office (YES or NO) Please Circle

If NO, who referred you to CREF: _____

INSURANCE INFORMATION

Patient's Primary Insurance Carrier		**Patient's Secondary Insurance Carrier**	
Insurance Co:		Insurance Co:	
Address:		Address:	
Phone#:		Phone#:	
ID#:		ID#:	
Group #:		Group #:	
Subscriber:		Subscriber:	

Are you covered under your spouse/partner's Insurance Plan? (YES or NO) Please circle

AUTHORIZATIONS: I authorize the undersigned medical providers to release any information in the course of my examination or treatment to my insurance company. I further authorize any benefits due for service rendered to be paid directly to Edwin D. Robins, MD, PS. I understand that if the physician's fees DO NOT meet my insurance carrier's customary and reasonable fee, I will therefore, be responsible for any balance due after insurance payments. I am financially responsible for any balance due, including services exceeding the limitations of my insurance policy.

SIGNATURE: _____ DATE _____

COPY OF INSURANCE CARDS & ID

NOTE: In order to control our costs, we request that office visits or copayments are to be paid at the time service is rendered. We would rather control our billing costs than to be forced to raise our fees.
Please indicate below how you wish to pay for your services.
CASH **PERSONAL CHECK** **MC** **VISA**