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

(Legal) Name:				Date of Birth:
	(First)	(Middle)	(Last)	
Address:				
(St	reet)	(City)	(State)	(Zip Code)
Home phone: ()		Social Security #: _	
Cell phone: ()		E-Mail Address:	
Patient employer: _			Occupation:	
May we contact you	u at work? Yes	. No	Work Phone #:	
Emergency Contac	t:		Phone #	
REFERRAL INF	ORMATION			
OB/GYN Physician	:		Phone #:	
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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 CHÉCK МC **VISA**

