

**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**

G:New Patient Packet FERT-Cref np demographics female 11/09