PALM BEACH FERTILITY CENTER
MARK DENKER, M.D.

Male Patient Registration

Last Name ______________________________ First Name ________________ MI ______ Date of Birth ___________

Address ____ City ___________________ State ________ Zip __________

Marital Status: ☐ Single ☐ Married ☐ Other: ____

Home Phone ____ Work Phone _________________________________

Cell Phone ____ E-Mail ____________________________________

Referring Physician's Name______________________________ Referring Physician's Phone No. ___________________

Referring Physician's Address ______________________ City ___________________ State ________ Zip __________

Occupation ____ Employer Name _________________________________

Employer Address __________________________________ City ___________________ State ________ Zip __________

Name of Spouse/Partner ____ Date of Birth ___________

Occupation ____ Employer Name _________________________________

Work Phone ____ Cell Phone __________________________________

Consent to Treat

While I am here, I permit the employees, the physician, and other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending physician will explain to me the nature of my condition and his recommended treatment and any associated risk involved. I also understand that he will explain to me other ways this condition could be treated. I further understand that this care may include tests, examinations, medical and/or surgical treatment. No guarantees have been made to me about the outcome of this care.

Assignment of Benefits

I authorize MARK DENKER, M.D., PA, to release to the insurance carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim be made directly to MARK DENKER, M.D., PA.

Financial Agreement

I understand that that I am financially responsible for all services received regardless of insurance payment or denial. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I understand that if I fail to obtain an authorization from my Primary Care Physician, where applicable, that I am solely responsible for payment of all charges. There is a $25 service charge on any returned checks.

Patient Signature ____ **Date** _________________

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I authorize Palm Beach Fertility to release the following information to: ____

Relationship ____ Date of Birth ___________

Select all that may be released: ☐ Lab Results ☐ Semen Analysis ☐ Financial Issues ☐ Other: ___________________

I understand that this authorization is valid for twelve (12) months from the date of signature unless otherwise revoked in writing to the address listed above.

Date _____________________________________

Patient Name (Printed)____

Patient Signature____

Subsequent Page Style