Creighton Model FertilityCare System
Information Card

WOMANS' NAME: _____ DOB: _____ ID # _____

MAN'S NAME: _____

Tele: (H)_____(W)_____Email address:_____

Woman's Address: _____

Referred by:_____ Date of inquiry:_____

Your personal OB/GYN or Family Doctor: _____ Date of last Pap smear:_____

Interested in _____ Online session _____In person Session

Reason for requesting an Introductory Session _____

Need invoices for sessions ____ sent electronically ____hard copy _____no need for it

Appointment for IS Date_____Woman ___Man ___Couple____In person____ Online

Attendance at IS Date_____Woman _____Couple_____Online _____ In person

Appointment for first Follow-up Date_____Woman _____Couple_____

Comments_____

___No appointments after IS ___ No materials taken ___Materials and list of FCP taken

Payment Record

Date	Visit (online O or in person P)	Amount Due	Amount paid	Payment method	Balance