Storage Client Information

*Account #*_____ *Account Type*_____ *Date Entered*_____

PLEASE LIST YOUR NAME EXACTLY AS YOU WANT THE SPECIMENS LABELED AND THE ACCOUNT LISTED.

☐ **Change existing account information as indicated below**

Client Name _____
(First, Middle Initial, Last)

*Address*_____
(Street and Apartment number)

*City*_____ *State*_____ *Zip*_____

*Home Phone*_____ *Work Phone*_____

*Cell Phone*_____

*Social Security #*_____ *Email*_____

*Birth Date*_____ *Occupation*_____

*Contact Person (other than self)*_____

*Relationship*_____

*Home Phone*_____ *Work Phone*_____

*Responsible Billing Party*_____

*Billing Address*_____

*City*_____ *State*_____ *Zip*_____

*Referring Physician*_____ *Referring Physician's Phone*_____

*Referring Physician's Address*_____

_____

How did you first learn about Fairfax Cryobank, Inc.? *Physician* *Friend* *Website* *Other*_____

Have you seen our brochure about sperm storage? *Yes* *No*

I acknowledge that I, the client, am ultimately responsible for payment for services rendered to me at Fairfax Cryobank, Inc. as long as the samples are stored in my name. Additional fees, including any collection costs, will be imposed on delinquent accounts.

*Signature*_____ *Date*_____