Fairfax Cryobank

AUSTIN, TX ● FAIRFAX, VA ● HOUSTON, TX ● PASADENA, CA ● PHILADELPHIA, PA ● ROSEVILLE, MN

Storage Client Information

Staff only:

Account Number		Account Type		Date Entered	

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

Legal First Name		Legal Middle Name		Legal Last Name	
Chosen Name					
Address Line 1					
Address Line 2					
City		State		Zip Code	
Phone Number 1			Phone Number 2		
	☐ Home ☐ Cell ☐ Work			☐ Home ☐ Cell ☐ Work	
Email			Occupation		
SSN			Date of Birth		
Gender Identity			Pronouns		

Contact Person		Relationship	
Phone Number 1		Phone Number 2	
	☐ Home ☐ Cell ☐ Work		☐ Home ☐ Cell ☐ Work

Responsible Billing Party		Relationship	
Billing Address Line 1			
Billing Address Line 2			
City		State	Zip Code

Referring Physician/Clinic		Phone Number	
Address			

How did you first learn about Fairfax Cryobank, Inc.? Physician Friend Website Other_____

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_____