HAMILTON LAW OFFICE

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SURROGATE MOTHER/GESTATION CARRIER INFORMATION

Date Completed: _____

Referred by: _____

PERSONAL DATA

SURROGATE MOTHER/ GESTATION CARRIER	**SPOUSE**
Full Legal Name _____	Full Legal Name _____
Residence _____	Residence _____
City _____	City
County _____	County _____
State, Zip _____	State, Zip _____
Phone number (work) _____	Phone number (work) _____
Phone number (home) _____	
Phone number (cellular)_____	Phone number (cellular)_____
E-Mail address _____	E-Mail address _____

Social Security Number _____ Social Security Number _____

Driver's License Number _____ Driver's License Number _____

How long has individual been a resident of:

County? _____ County? _____

State? _____ State? _____

Date of Birth:_____Age:_____ Date of Birth:_____Age:_____

MARITAL STATUS

Single _____ Married_____

(Answer only if currently married)

Date of this marriage: _____

Place of this marriage (City, State, & County): _____

Former (legal/maiden) name:

_____

CHILDREN:

Name: _____ M / F_____ Age:_____ Date of Birth: _____

Name: _____ M / F_____ Age:_____ Date of Birth: _____

Name: _____ M / F_____ Age:_____ Date of Birth: _____

HEALTH INSURANCE INFORMATION:

Do you personally have family health insurance available either through your employer or another group or organization? _____Yes _____No

Name of insurer _____

Address : _____ Telephone: _____

City :_____State:_____ Zip:_____

Participant card available? _____Yes _____No Prescription card available? _____Yes _____No

Who is covered by this plan? Names and Dates of Birth

_____

_____

Have you checked with your insurance provider to see if the surrogacy pregnancy will be covered by your insurance policy? _____ If so, will the pregnancy and delivery will be covered by your insurance plan? _____

FERTILITY CLINIC/MEDICAL FACILITY

Name of Fertility Clinic or Medical Facility:

Address: _____

City, State, Zip Code: _____

Phone Number: _____

Email address or Website:_____

Name(s) of attending physician or other attending medical persons (including credentials):

_____ _____

_____

Date of Initial visit at Fertility Clinic: _____

Date of Invitro Fertization: _____

Were the embryos cryopreserved? If so, Date embryos were Cryopreserved: _____

Date of Transfer: _____

Date of blood test confirming pregnancy: _____

Who performed the blood test?_____

Date of first ultrasound/and name of physician or medical person performing ultrasound: _____

HOSPITAL/CLINIC

Name of hospital or clinic where labor and delivery will occur: _____

Name of attending physician for labor and delivery: _____

Name of gynecologist if different than labor and delivery physician:

_____