

HAMILTON LAW OFFICE

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INTENDED PARENT(S)/ INFORMATION

Date Completed: _____

Referred by: _____

PERSONAL DATA

INTENDED PARENT

Full Legal Name _____

Residence _____

City _____

County _____

State, Zip _____

Phone number (work) _____

Phone number (home) _____

Phone number (cellular) _____

E-Mail address _____

Social Security Number _____

INTENDED PARENT

Full Legal Name _____

Residence _____

City _____

County _____

State, Zip _____

Phone number (work) _____

Phone number (home) _____

Phone number (cellular) _____

E-Mail address _____

Social Security Number _____

How long has individual been a resident of:

County? _____

County? _____

State? _____

State? _____

Date of Birth: _____

Date of Birth: _____

MARITAL STATUS

Single _____ Married _____

(Answer if married)

Date of this marriage: _____

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

Former legal name(s) prior to marriage:

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):

Name of third party coordinator for clinic: _____

Date of Initial visit to Fertility Clinic: _____

Date of Initial visit for Gestational Carrier if different than date above: _____

Date of Harvesting of oocytes (if applicable): _____

Date of Invitro Fertilization (or other type of fertilization if not Invitro): _____

Were embryos cryopreserved? If so on what date? _____

Date of transfer of embryo(s): _____

Number of embryos transferred: _____

Was there more than one transfer performed? _____

Date of blood test confirming pregnancy: _____

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

Did an egg donor or sperm donor provide genetic material? _____

If so, was either the egg donor or sperm donor anonymous? _____ If not anonymous, then please provide the party's name(s) and additional information.

HOSPITAL/CLINIC WHERE DELIVERY IS EXPECTED TO OCCUR

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

Name of attending physician for labor and delivery: _____

Name of gynecologist for gestational carrier if different than labor and delivery physician:

NAME(S) OF INTENDED CHILD(REN)

Please indicate the full legal name or names that you plan to give the child or children of this surrogacy agreement
