



IDANT

A DIVISION OF DAXOR CORPORATION

350 5th Avenue, Suite 7120, New York, N.Y. 10118

Phone: 212-244-0555 Fax: 212-330-8536

PATIENT T.D.I REQUEST APPLICATION

Dear Patient:

To order anonymous donor insemination units directly from us, you and your physician must complete the information below, and then return this information to IDANT. **This form only applies if you will be paying the charges. A valid credit card number must be provided.** You may mail or fax this information. A technician will contact you the following business day after we have received this form to confirm your request and begin processing your order.

Patient Information

Last name: _____ First name: _____

Address: _____

City/ State/ Zip Code: _____

Telephone number: _____ Fax number: _____

Email: _____

Age: _____ Marital Status (Single / Married / Separated / Divorced / Widowed)

I hereby give IDANT Laboratories my authorization to charge my **Visa / Mastercard / AMEX** (please circle one) for any charges incurred. I understand that a receipt for each transaction will be sent to me.

Credit card #: _____ Exp. Date: _____

Name as it appears on the credit card: _____

Authorized signature: _____

Physician / Clinic Information

Physician / Clinic name: _____

Address: _____

City / State / Zip Code: _____

Telephone number: _____ Fax number: _____

Physician / Clinic License Number (A copy must be provided): _____

Insemination License Number: (NY only) _____

Physician's signature: _____

FOR IDANT ACCOUNTING DEPARTMENT USE ONLY	
Date Received	
Account Number	
Issued by	
Date Issued	