MILFORD OB/GYN PHYSICIANS, P. C.

TIM SHARPE, M.D., F.A.C.O.G.
309 Seaside Avenue, Suites 203-204
Milford, Connecticut 06460
(203) 878-5913

Name:____
Last First Middle Initial

Date of birth:________________ Place of birth:____________________________

Address:____

City:____________________ State:____________ Zip:________________

Home Phone:____________________ Social Security Number:________________

Occupation:______________________ Work Phone:____________________

Place of Employment and city: ____

Marital Status (please circle): Married Engaged Single Divorced Widow
Living with a Partner: please specify Male or Female

*If you are **not** the primary holder of your health insurance, please provide the name of the person who is, their date of birth, their relation to you, and their Social Security Number:*

Name:____________________________________ Date of birth:__________

Relation to you: ______________ Social Security Number: ____________________

Assignment of Insurance Payments

Office policy requires payment at the time services are rendered. You will be furnished with a receipt for your insurance company to reimburse you directly. Upon your request, we will submit your insurance form for you. Please sign the authorization below assigning payments from the insurance company directly to this office. Charges or part of charges not covered by your insurance company will be your financial responsibility.

X ______________________________________ Date:__________________

Release of Medical Information

I hereby authorize any holder of medical information about me to release to H.C.F.A and its agents, or any other supplier of medical benefits, any information needed to detirmine those benefits, or the benefits payable for related services.

X_______________________________________ Date:__________________

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