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: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home # _____ Work # _____ Cell # _____
Best contact number: (circle one)

Email address: _____ Occupation: _____

Place of employment and city: _____

Date of last menstrual period: _____

Marital status (please circle): Married Engaged Single Divorced
Separated 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, and their relation to you.

Name: _____ Date of birth: _____

Relation to you: _____

Assignment of Insurance Payments

We will submit your insurance claim 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 determine those benefits, or the benefits payable for related services.

X _____ Date: _____