New York FERTILITY SERVICES
16 East 40th St, 2nd Fl, New York, NY 10016
Ph 212-679-2289 fax 212-679-2288

Demographic Face Sheet Form

Patient's Name_____ _____ _____
Last *First* *M.I.*

SS# _____ Date of Birth _____/_____/_____Sex: M / F Ethnicity:_____

Home Address _____Marital Status:_____

_____ _____ _____
City State Zip Code

Home # _____Work # _____ Cell # _____

May we email you confidential information and/or test results? **YES** **NO** **N/A**

Primary email address:_____

Name of emergency contact_____

Phone _____ **Relationship**_____

Please indicate the name and ID # of your insurance carrier. If you have **any insurance** it must listed below to cover any outside blood work – otherwise you will be billed in full these services.

Primary Insurance Name:_____ ID Number:_____

In order to be respectful of the medical needs of New York Fertility Services please be courteous and call the office promptly if you are unable to attend an appointment. There will be a "no show" fee of $75.00 charged if you do not cancel and don't keep your appointment. To cancel appointments please call 212-679-2289 at least 24hrs in advance.

By signing below I agree that the above information is accurate

X_____ Date_____
Patient signature

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