New York FERTILITY SERVICES
16 East 40th Street, 2nd Floor
New York, N.Y. 10016
212-679-2289 - 212-679-2288

Demographic Face Sheet Form

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

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

Home Address _____Marital Status:_____

Home # _____Work # _____ Cell # _____

Employer Name:_____ **Full time / Part time** Student**: Y / N**

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

Primary email address:_____

Name of emergency contact_____ Phone _____Relationship_____

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

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

Home Address_____

Cell # _____Work # _____

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

Primary email address:_____

Should both emails be included on all correspondence? Circle one **Patient email only / Patient & Partner email**

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

Primary Insurance Name:_____ ID Number:_____

Partner 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 and agree to the above terms.

X_____ Date_____

Patient signature

X_____ Date_____

Partner signature