Frederick R. Silfen, M.D.

Obstetrics ◆ Gynecology ◆ Infertility ◆ Menopausal Medicine

PATIENT INFORMATION SHEET

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: ( ) _____ Cellular Phone #: ( ) _____

Email: _____

Date of Birth: _____/_____/_____ Age: _____ Social Security #_____-_____-_____

Referred to practice by: _____

Employer: _____ Occupation: _____

Work Phone #: _____ Extension: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Spouse/Next of Kin: _____ Phone #: ( ) _____

Nearest Friend/Relative: _____ Phone #: ( ) _____

Relationship: _____

Pharmacy: _____ Phone #: ( ) _____

Name of **PCP** or General Practitioner: _____

INSURANCE INFORMATION

Primary: _____
HMO POS PPO INDEMNITY

_____
Subscriber: :Spouse Self Dependent

Phone Number: _____

Secondary: _____
HMO POS PPO INDEMNITY

_____
Subscriber: Spouse Self Dependent

Phone Number: _____

As a courtesy to our patients, our office will submit all charges incurred to your insurance company on record. It is the sole responsibility of the patient to notify our office, in writing, of any changes to their insurance policy. Any account balance remaining after a sixty (60) day period shall become the responsibility of the patient.

I certify that the above information is correct and further authorize the release of any medical information to your insurance carrier(s) for any claim. I request payment of authorized benefits for physician's services to the physician furnishing the service, or authorize the physician to submit a claim for me. I also agree that should this account be referred to any agency or attorney for collection, I will be responsible for all collection fees, attorney fees and court costs. *There will be a minimum charge of $50.00 for all balances sent to collections.* I am also aware that **payment is expected when services are rendered**, unless prior arrangements have been made.

Signature: _____ Date: _____