LIFESPRING WOMEN'S HEALTHCARE

J. Todd Hannah, MD Lawrence Schmitz, MD* Amy Fry, MD*
Lorie Oswalt, APN Jeanice Ball, APN*

REFERRED BY_____

PATIENT NAME_____ Previous Last Name: _____

MARITAL STATUS: S M D W SS#_____ DOB _____

ADDRESS_____APT_____

CITY/STATE/ZIP_____

HOME PHONE_____ CELL PHONE_____

EMPLOYER_____ EMAIL_____

PREFERRED PHARMACY _____ **LOCATION**_____

SPOUSE OR GUARDIAN
NAME_____DOB_____ SS#_____

EMPLOYER_____HOME PHONE_____CELL PHONE_____

EMERGENCY CONTACT
NAME_____ RELATIONSHIP_____ PH#_____

INSURANCE INFORMATION: (PLEASE INCLUDE THIS INFORMATION, EVEN IF CARDS WERE SCANNED)

PRIMARY INSURANCE:_____ SECONDARY INSURANCE:_____

PRIMARY ID#_____ SECONDARY ID#_____

PRIMARY GROUP#_____ SECONDARY GROUP#_____

WHO IS THE INSURANCE SUBSCRIBER? (circle one): PATIENT SPOUSE/GUARDIAN OTHER

IF MARKED OTHER, PLEASE NAME SUBSCRIBER BELOW:

SUBSCRIBER NAME:_____DOB_____ SS#_____

EMPLOYER_____ RELATIONSHIP TO PATIENT_____

By signing below I authorize that all insurance payments, if any, be made payable to the provider of service. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. All charges are due and payable at the time of services unless otherwise specified. I authorize the use of this signature of all insurance submissions. I agree that all information listed above is true to the best of my knowledge.

PATIENT/LEGAL GUARDIAN SIGNATURE:_____ DATE:_____

I understand the Cancellation Policy of Lifespring Women's Healthcare. (A copy is available at the front desk) Please initial _____

I understand the Lab Consent Policy of Lifespring Women's Healthcare. (A copy is available at the front desk) Please Initial _____