LINTECUM AND NICKELL, P.C.

Obstetrics and Gynecology

PATIENT INFORMATION SHEET

FOR OFFICE USE ONLY
PHYSICIAN: _____
PATIENT # _____

*****In order to contain costs, we expect payment in full at the time of service unless other arrangements have been made.*****

CELL #

PATIENT INFORMATION

LAST NAME	FIRST	M.I.	SEX	DATE OF BIRTH	MARTIAL STATUS S M W D

ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY NO.	HOME PHONE NO.	OCCUPATION	WORK PHONE NO.

YOUR EMPLOYER | ADDRESS

SPOUSE'S NAME (OR PARENT) | SPOUSE'S (OR PARENT'S) DATE OF BIRTH AND SOCIAL SECURITY NO.

SPOUSE'S (OR PARENT'S) EMPLOYER | SPOUSE'S (OR PARENT'S) WORK PHONE

DR. REFERRED BY:

DRUG ALLERGIES

WHO SHOULD WE NOTIFY IN CASE OF EMERGENCY? (OTHER THAN SPOUSE)

NAME | PHONE NO.

ADDRESS | RELATIONSHIP

INSURANCE INFORMATION

PRIMARY INSURANCE CO.		**SECONDARY INSURANCE CO.**	
INSURANCE COMPANY NAME		INSURANCE COMPANY NAME	
GROUP NO.	ID NO.	GROUP NO.	ID NO.
INSURANCE COMPANY ADDRESS		INSURANCE COMPANY ADDRESS	
EMPLOYER	POLICY HOLDER	EMPLOYER	POLICY HOLDER

ATTENTION MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Lintecum & Nickell, P.C. for any services furnished by that group. I authorize any medical information about me to be released to the Health Care Financing Administration and its agents as needed to determine these benefits or the benefits payable for related services.

PATIENT'S SIGNATURE _____ DATE SIGNED _____

MEDICAL AUTHORIZATION AND PATIENT AGREEMENT

While I am here I permit the employees, the doctor, and all other persons caring for me to treat me in ways they are beneficial to me. I understand that the attending physician will explain to me the nature of my condition and his/her recommended treatment and any associated risk involved. I also understand that he/she will explain to me other ways this condition could be treated. I further understand that this care may include diagnostic testing, examinations, medical and/or surgical treatment and no guarantees have been made to me about the outcome of this care.

I understand and agree that if my Employer, Workman's Compensation Carrier, or my Insurance Plan does not pay in full that I/we will be responsible for payment for all charges. I/we also agree that in the event of collection, I/we agree to pay all outstanding charges, costs of collection including reasonable attorney's fees. I hereby authorize Lintecum & Nickell, P.C., to release all information necessary to secure payment. I assign all benefits for unpaid services to which I am entitled to Lintecum & Nickell, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand and agree to the financial policy as stated above.

PATIENT'S SIGNATURE _____ DATE SIGNED _____