

LIFESPRING WOMEN'S HEALTHCARE
1200 S.E. 28th St., Suite 2
Bentonville, AR 72712

DR. TODD HANNAH *DR. LAWRENCE SCHMITZ * DR. AMY FRY * LORIE OSWALT,
APN

Today's Date _____ Referred by _____

Patient's Name _____ Date of Birth _____

Address _____ City _____

State _____ Zip _____ SS# _____

Hm# _____ Wk# _____ Cell# _____

E-Mail: _____ Employer _____

Employer Address _____

Spouse Name _____ Date of Birth _____

SS# _____ Wk# _____

Spouse Employer _____

Person to Notify in Case of an Emergency _____

Relationship to Patient _____ Ph# _____

Insurance (s) _____

Policy Holder Name _____ Date of Birth _____

ID# _____ Group# _____

PLEASE HAVE INSURANCE CARD (S) AVAILABLE FOR A COPY!

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 for all insurance submissions.

Responsible Party Signature

Relationship

Date