

**LIFESPRING WOMEN'S HEALTHCARE
1200 S. E. 28th STREET
BENTONVILLE, AR 72712**

Dr. Amy Fry

Dr. Todd Hannah

Dr. Lawrence Schmitz

Today's date _____ Referred by _____

Patient's Name _____ Date of Birth _____

Address _____ City _____

State _____ Zip _____ SS# _____

Hm# _____ Wk# _____ Cell# _____

Employer _____ How Long _____

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 CARDS 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 service unless otherwise specified. I authorize the use of this signature of all insurance submissions.

Responsible Party Signature

Relationship

Date