DEMOGRAPHIC DATA
OB/GYN ASSOCIATES OF LANCASTER, INC
Obstetrics and Gynecology

Sarah L. Froman, M.D., Laurel J. Santino, M.D., Suzanne M. Barnhart, M.D., Brandie J. Shirey, MSN, CNP.

As a service to you, our patient, we file insurance claims to your primary and secondary insurance companies, we also supply information to the labs we use. THEREFORE, IT IS EXTREMELY IMPORTANT AND NECESSARY THAT YOU SUPPLY US WITH THE CORRECT INFORMATION EACH TIME YOU COME TO US FOR CARE.

PATIENT NAME

First _____ Mi _____ Last _____ Maiden _____

Date Of Birth_____ Social Security Number_____ Marital Status_____ Age_____

Street Address_____

City_____ State_____ Zip_____

Email Address: _____

Home Phone (____)_____ Day Time/ Work Phone (___)_____ Cell Phone(___)_____

In Case of an Emergency Notify_____ Day Time Phone (___)_____

Relationship to Patient_____

In the event that OB/GYN Associates of Lancaster, Inc, it unable to contact me personally, I give my permission for them to give any test results, financial information, appointment time or messages to _____

Phone(____)_____

This Permission may be revoked at anytime. Please inform us if you do NOT want messages of appointments, test results, and/or referral information left on your answering machine.

OTHER PHYSICIANS

Referring_____ Phone (_____)_____

Family_____ Phone (_____)_____

YOUR EMPLOYER

Employers Name_____ Occupation_____

Address_____ Phone (____)_____

Working Hours_____ May we call you at work? _____

WHO IS THE SUBSCRIBER OF YOUR INSURANCE POLICY? (Is the insurance through you, your spouse, or legal guardian?)

Name_____ Relationship_____ Social Security Number_____

Address_____

Date of Birth_____ Phone Number (____)_____

Occupation_____ Employer_____

Primary Insurance

Insurance Name_____

Secondary Insurance

Insurance Name_____

Does your insurance require a referral from your primary care physician? Yes_____ No____

If yes, did you do this? Yes___ No_____

SIGNATURE ON FILE

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of my records. I hereby assign all medical and or surgical benefits, including major medical benefits, to which I am entitled, including private insurance and other health care plans, including Medicaid and Medicare to Sarah L. Froman, M.D., Laurel Jozwiak Santino, M.D., and Suzanne M. Barnhart, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be as valid as an original. I understand that the information I am authorizing you to release may be confidential nature, and that the insurance carrier may use this information as they wish. I understand that I am financially responsible for all charges whether or not paid by insurance, Medicaid, or Medicare. In the event my bill is not promptly paid, information contained herein may be used in the collection process. I hereby authorize Dr.Froman, Dr. Santino, and Dr. Barnhart to release all my information necessary to secure the payment.

_____ _____

Patient Signature/Legal Guardian **Date**