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Kathy Lamb, A.R.N.P.

Dennis P. Dornbier, D.O., F.A.C.O.G.
Tamara M. Dassanayake, M.D., F.A.C.O.G.
Sue Moravec, A.R.N.P.

Stephen M. Feltz, M.D., F.A.C.O.G.
Francesca M. Turner, D.O., F.A.C.O.G.
Darci Lewis, A.R.N.P.

PATIENT INFORMATION

Name: _____ Age: _____ Date of Birth: _____
Have you been a patient of any of our Clinic physicians? _____ If yes, When? _____
Were you seen at the office? _____ Hospital? _____ Has your name changed since your last visit? _____
If yes, what was your name and address at the time of your last visit? _____

Current Address: _____
(STREET CITY STATE ZIP)

Primary Phone #: _____ Secondary Number: _____

Single: _____ Married: _____ Divorced: _____ Separated: _____ Social Sec. No. _____

Employer: _____ Business Address: _____

Occupation: _____ Business Phone No. _____

Husband's Name: _____ Date of Birth: _____ Social Sec. No. _____

Employer: _____ Business Address: _____

Husband's Occupation: _____ Business Phone No. _____

CONTACT IN CASE OF EMERGENCY: (Friend or Relative, NOT HUSBAND)

Name: _____ Relationship: _____

Address: _____ Phone: _____

INSURANCE

POLICYHOLDER (Self/Spouse/Parent)

Blue Shield _____
(ID Number) First Name Last Name

Medicare _____
(9-digits w/letter) First Name Last Name

OTHER INSURANCE

ADDRESS: _____

ID NO. _____ POLICYHOLDER: _____
First Name Last Name

Does your insurance require specific hospital or lab? Yes _____ No _____ Name _____

Does your insurance company require notification upon admission to hospital? Yes _____ No _____

Referring Physician (if applicable): _____ ADDRESS: _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

I understand that I am personally responsible for the amount not paid by insurance, including co-payments and deductibles which are to be paid at the time of service.

I hereby authorize the release of any information acquired in the course of my examination or treatment for the processing of an insurance claim. I also request that payment of authorized Medicare benefits and any other insurance benefits be made to Obstetrical & Gynecological Associates P.L.C., Des Moines, Iowa for any services provided to me by them.

Signature: _____ Date: _____