LSC OB-GYN LLC

Patient's
LAST NAME:________________________ FIRST NAME:____________________ M.I:________
BIRTHDATE:______/______/______ SOCIAL SECURITY:____________________________
ADDRESS:____
CITY:_______________________________ STATE CODE:________ ZIP CODE:__________
REFERRING DR. PHONE #:___________________________ SEX (M/F):___________
MARITAL STATUS (S M D W):___________________________
HOME PHONE: (______)_________________________ CELL PHONE: (_______)__________
EMAIL:____
LANGUAGE:__________________________ RACE:______________ ETHNICITY:__________

EMERGENCY CONTACT:___________________________ EMER PHONE: (_______)__________

=========WORK INFORMATION=============================SPOUSE INFORMATION=========

Place of work:________________
OCCUPATION:________________
WORK PHONE: (________)________
EXT:__________

NAME:____________________
DOB:____________________

=================================Guarantor Information (If under 18)=====================

Guarantor First and Last Name:_______________________________________
Address:____
City:______________________________ State Code:____________ Zip code:__________
Telephone Number:____

Patients Authorization

I authorize LSC OB-GYN LLC to apply for benefits on my behalf for services rendered by LSC OB-GYN LLC. I request payment from my insurance company be made directly to LSC OB-GYN LLC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

____ ____________

Signature of Subscriber or Beneficiary

Date

Lori M. Sweitzer, D.O.

Name:____

Age_______ DOB______________ Date:___________________

Reason for Visit (please be as specific as possible):____

____

____

Medications:____

____

Drug Allergies________________________ Gardasil Vaccine _______________
Contraception_________________________

Last: PAP________ Mammogram________ Bone Density________ Colo Screen_________

Past Medical History:
Last Menstrual Period:__________Number of Pregnancies:________Deliveries________

History of: Herpes__ Chlamydia___ Gonorrhea___ Syphilis____Hepatitis ___HIV___HPV___

Medical Conditions: Check if you have a personal history of:
__Asthma __Cancer __DVT __Depression/Anxiety __Diabetes
__Gastric Reflux __Heart Disease __Heart Murmur __Hepatitis __IBS
__Kidney Stone __Migraine __Osteoporosis __Seizures __Thyroid Disease
__UTI
Other MEDICAL CONDITIONS? If yes list:

____

____

List all SURGERIES and DATES:

____

____

Family History:
Breast, Ovarian, Cervical or Uterine Cancer? Who? What type?

____

Social History____
Marital Status:______ Sexually Active:_______ Tobacco use:_______ Alcohol:__________
Other Drug use?_______

"Front only"