

OB Hospital
LTN E SMC E
SKY E

PT# Dr.#
NEW E EST E
GYN E OB E
Coplay \$ _____

South Denver Obstetrics & Gynecology, P.C.

*Dr. Kelly Lennon, Dr. Scot Graham, Dr. Lisa Becker, Dr. Roy Bergstrom,
Sue Saindon C.N.P., Diana Buckwalter C.N.P.*

Please Print Legibly:

Legal Name _____ Name Preference _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ SOCIAL SECURITY # _____ Marital Status _____

Your ethnic origin/race _____ E-mail _____ Co-pay \$ _____

Your Employer _____ Your Primary Physician _____

How did you learn of our practice? Yellow Pages Internet Insurance Friend Relative
Newspaper Doctor _____ Other _____

Insurance Information:

Primary Ins. Name _____ Secondary Ins. Name _____

Claims Address _____ Claims Address _____

Policy ID# _____ Grp.# _____ Policy ID# _____ Grp.# _____

Insured's Employer _____ Insured's Employer _____

Subscriber Name _____ Subscriber Name _____

Relationship to Patient _____ Relationship to Patient _____

SS# OF SUB. _____ SS# OF SUB. _____

Sub. Date of Birth _____ Sub. Date of Birth _____

Employee is: Active Retired Employee is: Active Retired

Is this COBRA coverage? Yes No Is this COBRA coverage? Yes No

Emergency Contact Information:

Name _____ Phone _____ Relationship _____

Financial Agreement/Assignment of Benefits

I hereby give authorization for payment of benefits to be made directly to S. Denver OB-GYN and any associated entities for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I agree to pay all costs of collection, and reasonable attorney's fee, if incurred, in the process of collection. I hereby authorize this health-care provider to release all information necessary to secure the payment of benefits.

Please note there is a \$20.00 charge for appointments missed without at least a 24 hours notice.

SIGNATURE _____ DATE _____