

# LINCOLN CENTER OB & GYN, PA

Central Office:  
800 SW Lincoln St  
Topeka, KS 66606

West Office:  
2830 SW Urish Rd  
Topeka, KS 66614

Chart Number: \_\_\_\_\_ Lincoln Center Doctor: \_\_\_\_\_

## PATIENT INFORMATION (Please notify our office of any changes in the following information)

Name: \_\_\_\_\_  
Last First Middle Suffix

Address 1: \_\_\_\_\_  
(If P.O. Box, WE MUST ALSO HAVE HOUSE ADDRESS)

Address 2: \_\_\_\_\_

\_\_\_\_\_ City State Zip

\_\_\_\_\_ Social Security No. Date of Birth Marital Status Primary Care Doctor

\_\_\_\_\_ Home Phone No. Work Phone No. Ext Cell Phone No. Referring Doctor

\_\_\_\_\_ Employer Occupation Email Address

\_\_\_\_\_ Spouse/Parent's Name – (or nearest friend/relative) How Related?

\_\_\_\_\_ Their Home Phone No. Their Work Phone No. Ext Their Cell Phone No.

## IF INSURANCE REQUIRES A REFERRAL, PLEASE HAVE IT WITH YOU OR HAVE IT MAILED TO US

\_\_\_\_\_ Health Insurance Company No. 1 Effective Date Policy ID No. Group No.

\_\_\_\_\_ Name Policy is under Suffix Date of Birth Employer Sex

\_\_\_\_\_ Health Insurance Company No. 2 Effective Date Policy ID No. Group No.

\_\_\_\_\_ Name Policy is under Suffix Date of Birth Employer Sex

## OFFICE CREDIT POLICIES:

Payment is requested when service is rendered. OB patients without insurance must have their estimated fee paid in full by delivery date.

I hereby assign benefits from Medicare/Medigap/Medicaid/my Health Insurance(s) to the Lincoln Center OB-GYN, P.A., Doctors M. Morrison, Field-Kresie, Trobough, Gleason, Dickson, Bonebrake, Babin, Teply and H. Morrison for all services billed to Medicare/Medigap/Medicaid/my Health Insurance Company(s) for which I have not paid in full. A copy of this assignment shall be as valid as an original.

I understand I will be financially responsible for any services considered to be non-covered by Medicare/Medigap/Medicaid/my Health Insurance. If my account is turned over to a collection agency, I understand that I may be subject to interest charges.

I authorize the release of any medical information necessary to process my claims, and for Utilization Review/Chart Audits that may be required under the guidelines of my insurance company.

It is understood and agreed that the physicians of Lincoln Center OB-GYN, P.A. have the right to designate which doctor(s) will perform medical services requested by the undersigned patient.

**Dated:** \_\_\_\_\_ **Signed:** \_\_\_\_\_