Sarah Artman, M.D.
Board Certified Gynecology
Fellow, American College of
Obstetricians and Gynecologists

3535 Fishinger Boulevard
Suite 280
Hilliard, OH 43026
(614) 777-1440

New Patient Information and Forms

Your Appointment Date: _____

Dear Patient:

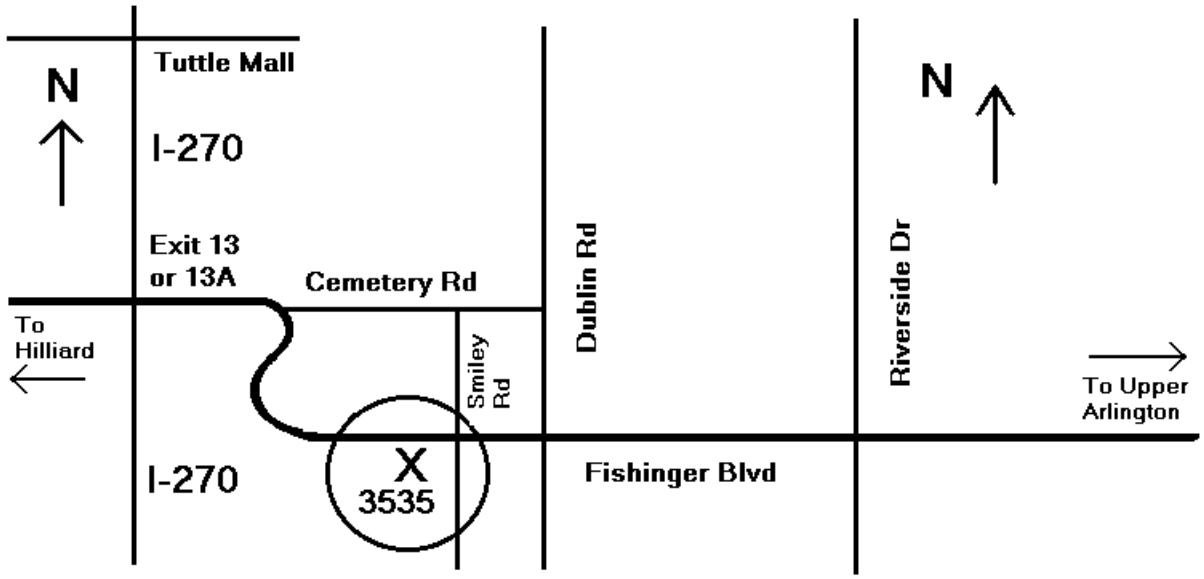
Thank you for making an appointment to begin your gynecologic care with our practice. We are posting our initial patient history forms so that you will be able to prepare for your visit. Please print out and fill in these forms and bring them with you to our office. Please do not worry if any of the terms are unfamiliar to you, as we will review your history during your visit. If you are unable to fill out the forms before your visit, please try to arrive at least 15 minutes early.

Our office is located in the Mill Run area of Hilliard. This is located off I-270 at the Fishinger/Arlington exit. Our building is a two-story brick building on the south side of Fishinger Boulevard, next to the fire station. Please check the map below, and if you are unsure how to find us, please call to clarify directions.

We look forward to meeting you and we hope you will feel pleased by your visit with us.

Sincerely,

Sarah Artman, M.D.



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PATIENT REGISTRATION FORM

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Patient last name _____ First name _____ M.I. ____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone (___) _____ Work phone (___) _____ Marital Status: S M W D

S.S. # _____ Date of birth _____ Age _____

Employer _____

Address _____ City _____ State _____

Occupation/type of work _____

SPOUSE, SIGNIFICANT OTHER, OR PARENT

Name _____ Relationship _____

Address _____ Home Phone # (___) _____

Employer _____ Work Phone _____

Another relative or friend (not living with you) _____

Relationship _____ Phone # (___) _____

INSURANCE INFORMATION

Company name _____

Address _____ Effective date _____

Subscriber # _____ Policy # _____ Group # _____

Second insurance co. _____ Subscriber # _____ Group # _____

Name of Insured (as it appears on card) _____

GUARANTOR INFORMATION

Please complete the section below if someone *other* than the patient is responsible for the bill.

Name _____ Street Address _____

City _____ State _____ Zip _____

Home phone (___) _____ Relationship to patient _____ Occupation _____

Employer _____ Work Phone _____

Employer's address _____

REFERRAL INFORMATION

Referred by _____ Referring physician _____

Family physician _____ Phone # (___) _____

Permission is granted to Sarah Artman, M.D. and/or her employees to perform such procedures as may be necessary to diagnose, treat, and care for the needs of myself or of the dependent for whom this form is completed. I understand that payment is required at the time of service, except for surgical procedures, unless other arrangements are made in advance. Where applicable, I authorize and assign payment of medical benefits directly to Sarah Artman, M.D., Inc. from any approved insurance that I have. I authorize Sarah Artman, M.D., Inc. to release any medical information to insurance carriers that is required for the processing of claims when appropriate. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature _____ Date _____

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CONSENT FOR RELEASE OF INFORMATION

This form gives us easy access to your contact numbers, and tells us your preferred method of communication.

Where are we allowed to attempt to contact you with test results?

HOME: YES NO (Please circle)

If yes, what is your home telephone number? _____

WORK: YES NO (Please circle)

If yes, what is your work telephone number? _____

CELLPHONE: YES NO (Please circle)

If yes, what is your cell number? _____

Many times when calling, we reach an answering machine or voice mail. Are we allowed to leave a detailed message with test results? YES NO

May we text your cell for appointment reminders? YES NO
(We will not text medical information.)

May we email you with appointment reminders? YES NO

If yes, what is your email? _____
(We will not email medical information.)

Please list family members to whom we are permitted to give test results:

Name and relationship: _____

Many times when calling, we reach an answering machine or voice mail. Are we allowed to leave a detailed message with test results? YES NO

Print Patient Name: _____

Patient signature: _____ Date: _____