LifeStem
Intake Form

Name:_____ Today's Date:_____

Date of Birth:_____ Gender: M F Marital Status: S M D W

Social Security Number:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

eMail Address:_____

Is it ok to leave a message on your voicemail or answering machine? Yes No

Is it ok to text you? Yes No Preferred method of contact:_____

Emergency Contact Name:_____

Emergency Contact Phone Number:_____

Insurance Company:_____

Secondary Insurance Company:_____
Please give all insurance cards to the receptionist to be copied.

I give permission for LifeStem to file for and accept payment through my insurance company for any covered treatment. I understand that regenerative medicine is not covered by most insurance plans. LifeStem will require payment for non-covered services, deductibles and co-pays in advance. We are pleased to offer financing through CareCredit (apply at www.carecredit.com).

I further agree that if my bill must be turned over to a third-party collection agency for non-payment, a collection fee of 30% will be added to my bill as allowed by Georgia Statute O.C.G.A.-13-1-11.

Patient or Guardian Signature:_____

Date:_____