Acct # ________________ Date: ________________

PATIENT INFORMATION:

Name of Patient ________________________________ Sex ____ M ____ F

Home Address

________________________________ City ____________ State ____________ Zip ____________

Home Telephone ( ) __________ Cell Phone ( ) __________ Fax ( ) __________

Email ____

Birth date ____________ Age ____________ Social Security # ________________

Married ________ Single ________ Widowed ________ Divorced ________ Separated ________

Occupation ________________ Employer ________________

Business Address Business Phone ( ) ____________

____

Name of Spouse ________________ Occupation ________________

Employer ________________ Business Address ________________

________________ Business Phone ( ) ____________

Name of Friend or Relative ________________________________

Relationship ________________ Phone ( ) ________________

Address

____

Name of Insurance company ________________________________

Address ____

Name of Policy Holder ________________________________

Policy Number ________________ Group Number ________________

Medicare Number ________________________________

PLEASE PRESENT INSURANCE CARD FOR SECRETARY TO PHOTOCOPY

Doctors seen in past year

____

Referred by ________________ Driver's License # ________________

I request that payment of authorized Medicare and/or Insurance benefits be made payable on my behalf to Robert M. Davidson, M.D., for services furnished me by that physician. I hereby authorize said assignee to release all information necessary to secure the payment. I also understand that any unpaid balance is my responsibility.

Date ________________ Signature ________________________________