Janet E. Davis, M.D., P.C.

Maternal Fetal Medicine

Today's Date:	Referral Source:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	□ Mr. □ Miss □ Mrs. □ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? □ Yes □ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:

Street address:	Social Security #: - -	(Home/Cell) Phone # ( ) -

P.O. Box/Apt#:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer Phone #: ( ) -

Employer Address:

Emergency Contact Name:	Phone #:	Relationship to Patient:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	(Home/Cell) Phone #: ( ) -

Is this person a patient here? □ Yes □ No

Occupation:	Employer:	Employer address:	Employer Phone #: ( ) -

Is this patient covered by insurance? □ Yes □ No

Please indicate primary insurance:

Subscriber's Name:	Subscriber's SSN: - -	Birth Date: / /	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other:

Name of secondary insurance (if applicable):	Subscriber's Name:	Group #:	Policy #:

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other:

SPOUSE INFORMATION

Name:	SSN: - -	(Home/Cell) Phone #:	Employer Phone #:
Employer:	DOB: / /	( ) -	( ) -

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Janet E. Davis, M.D., P.C. or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date

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