

NEW PATIENT INFORMATION

NAME _____

ADDRESS _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE# _____ WORK # _____ CELL# _____

RACE _____ EMAIL _____

SOCIAL SECURITY # _____ / _____ / _____ BIRTHDATE _____ / _____ / _____

EMPLOYER _____ MARITAL STATUS: _____

____ Spouse ____ Parent ____ Guardian Name _____

(check one of the above)

IF A MINOR-PARENT'S SOCIAL SECURITY # _____

EMERGENCY CONTACT NAME (NOT AT SAME ADDRESS) _____

RELATIONSHIP _____ PHONE # _____

DO YOU HAVE INSURANCE ____ Yes ____ No

(If yes, provide insured persons information below)

NAME _____ EMPLOYER _____

SS# _____ DATE OF BIRTH _____

PLEASE READ CAREFULLY:

Collection Policy: Because of skyrocketing increases in overhead and lower reimbursement, we have been forced to adopt a collections policy, which is outlined in a separate handout. In summary, if you do not have insurance, we require payment for the office visit the day of service. If you do have insurance, Co-payments must be made on the day of the visit. We also ask for payment of the estimated patient charges, prior to surgery.

I hereby authorize Dr. Davenport to render medical service to me.

DATE _____ SIGNATURE _____

Insurance Information: If you are covered by medical insurance please allow us to scan your card into our computer. For your convenience, our office will submit a claim form to your insurance company each time a charge is posted to your account. Please read and sign below.

I hereby authorize Dr. Davenport to release to my insurance company any information acquired in the course of my examination and treatment. I hereby authorize benefits to be paid directly to them but understand that payment for services rendered is ultimately my responsibility.

DATE _____ SIGNATURE _____