J. Kenneth Davis M.D.
Patient Information Form

Please print and complete **ALL** entries

PATIENT NAME (LAST, FIRST, MIDDLE) MARITAL STATUS DATE

SOCIAL SECURITY NUMBER DATE OF BIRTH AGE

STREET ADDRESS HOME PHONE

CITY, STATE, ZIP CELL PHONE

NAME OF EMPLOYER OCCUPATION WORK PHONE

EMPLOYER ADDRESS-STREET, CITY, STATE, ZIP

SPOUSE/ SO OR PARENT IF UNDER 18 DATE OF BIRTH SOCIAL SECURITY NUMBER

ADDRESS (IF DIFFERENT) STREET, CITY, STATE, ZIP

EMPLOYER OCCUPATION WORK PHONE

INSURANCE COMPANY ID NUMBER

POLICY HOLDER RELATIONSHIP DATE OF BIRTH

EMPLOYER

PRIMARY CARE DOCTOR PHONE

HOW DID YOU HEAR ABOUT US? __FAMILY/ FRIEND_____ __ INTERNET
__PHONE BOOK __INSURANCE __OTHER_____

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT AND WILL NOTIFY YOU OF ANY CHANGES IN THE ABOVE INFORMATION. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM AND I ASSIGN TO THE PHYSICIAN PAYMENT FOR MEDICAL SERVICES.

SIGNATURE_____

PARENT IF UNDER 18_____

PLEASE BRING ALL HEALTH INSURANCE CARDS TO RECEPTIONIST TO COPY