

**Davis Family Practice
Patient Registration**

(Please print clearly and complete ALL information)

Patient Information

Last Name _____ **Legal First Name** _____ **M.I.** _____
Address _____
Zip _____ City _____ State _____
Home Telephone _____ (Cell) _____ (Work) _____
Date of Birth _____ Age _____ Sex _____ **SS#** _____
Relationship to Guarantor: Self _____ Spouse _____ Child _____ Other _____
Marital Status: S M W D Spouse's Name _____ Student? F/T P/T Employed F/T P/T
Family Doctor _____ Referred By _____

Guarantor Information (Person Responsible for Payment)

Last Name _____ **Legal First Name** _____ **M.I.** _____
Address _____
Zip _____ City _____ State _____
Home Telephone _____ Work Telephone _____
Date of Birth _____ **SS#** _____
Guarantor's Employer _____
Employer's Address _____

Insurance Information

Primary Insurance Company _____ Phone _____
Address _____ City _____ State _____ Zip _____
Policy Holder: Name _____ Employer _____
Date of Birth _____ Sex _____ Patient's Rel. to Policy Holder _____
Other Covered Family Members _____
Group Number _____ Policy ID Number _____ Eff. Date _____
Deductible _____ Co-Payment _____ % Ins. Payment _____

Secondary Insurance Company _____ Phone _____
Address _____ City _____ State _____ Zip _____
Policy Holder: Name _____ Employer _____
Date of Birth _____ Sex _____ Patient's Rel. to Policy Holder _____
Other Covered Family Members _____
Group Number _____ Policy ID Number _____ Eff. Date _____
Deductible _____ Co-Payment _____ % Ins. Payment _____

I hereby give permission to treat me or my dependants as necessary. I understand my insurance company may assist me in paying all medical costs, but that I am ultimately responsible for all medical services rendered, and if necessary, I agree to pay all reasonable and customary collection fees and/or attorney's fees that may be incurred due to any delinquent accounts I may have.

I authorize the release of any medical information necessary to process the claim to my insurance company. I furthermore authorize payment of medical benefits directly to my physician for services rendered.

Signature _____ Date _____

