NAME: ____ S.S. # ______________
Last First Middle

SEX _____ M _____ F BIRTHDATE _____ / _____ / _____ AGE ______

MARITAL STATUS _____ S _____ M _____ D _____ W SPOUSE'S NAME ______________

ARE YOU A PERMANENT RESIDENT OF FLORIDA? YES _____ NO _____
IF NO, WHAT MONTHS ARE YOU RESIDING IN FLORIDA? FROM _________ TO _________
DRIVER'S LICENSE # ______________________ STATE ______
PERSON RESPONSIBLE FOR PAYMENT: ______________________

LOCAL ADDRESS:

____ ( )
Street City State Zip Phone

PERMANENT ADDRESS:

____ ( )
Street City State Zip Phone

PLEASE INDICATE INSURANCE CARRIERS BELOW (PRIMARY #1, SECONDARY #2)

_____ MEDICARE NUMBER # ______________________
Are you retired? YES _____ NO _____ NEVER EMPLOYED _____
If so, Date of Retirement: ______________________
Month/Year
If never employed, your Spouse's Date of Retirement: ______________________
Month/Year

_____ BLUE CROSS/BLUE SHIELD OF ______________ I.D.# ______________
Name of Subscriber: ______________ GROUP # ______________
Address: ______________ Phone: ______________

_____ OTHER INSURANCE COVERAGE ______________________
Name of Subscriber: ______________ I.D.# ______________
Address: ______________ Phone: ______________

_____ MEDICAID # ______________ EFFECTIVE DATE ______________

_____ I DO NOT HAVE INSURANCE COVERAGE.

ARE YOU EMPLOYED? YES _____ NO _____

EMPLOYER'S NAME: ______________________ Work Phone: ______________

Address: ______________________
Are you covered by your employer's insurance? YES _____ NO _____

REFERRED BY: ______________ FAMILY PHYSICIAN: ______________
Address: ______________ Address: ______________

IN CASE OF EMERGENCY, PLEASE LIST 2 PERSONS WE MAY CONTACT, OTHER THAN SPOUSE

Name: ______________ Name: ______________
Address: ______________ Address: ______________
Phone: ______________ Phone: ______________
Relationship: ______________ Relationship: ______________

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LIFETIME INSURANCE ASSIGNMENT

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agents of my insurance companies listed or to my employer if this is a Worker's Compensation claim, any information, including retirement dates, needed for this or a related insurance or Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of Medicare insurance benefits either to myself or to the party who accepts assignment.

I understand that I am responsible for payment of this account which includes all outstanding balances not covered by Medicare and/or insurance companies. I understand that a credit report may be obtained and reviewed. I understand that a billing charge of 1% per month will be added to my account if my payment is not received within 30 days of appointment. I agree to assume any necessary attorney or legal fees involved with collection of this account, should it become delinquent (60 days).

Patient's Signature ____________________ **Date** ____________________

I have been allowed to read the "Notice of Privacy" for the office of Edward L. Davis, D.O. I understand that I may request a copy of this document.

Patient's Signature ____________________ **Date** ____________________

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