Robert A Davis, MD Patient Information Form

Patient Information Account #_____

Legal Name_____ Date of Birth_____
(Last) (First) (Middle)

Mailing Address_____
City_____ State_____ Zip_____
Physical Address (if different from mailing)_____
Home Phone_____ Work Phone_____ Cell Phone_____
Sex: M / F Marital Status: S / M / D / W
Employer_____ City_____
Spouse_____ Spouse DOB _____
If a physician or other medical provider referred you, who referred you_____
Race (circle one): American Indian or Alaskan Native Asian Black or African American
Native Hawaiian or other Pacific Islander White
Ethnicity (circle one): Hispanic or Non Hispanic
Preferred Language (circle one if preferred): English Spanish Other_____
Email address:_____
Preferred Method of contact (circle one): Phone Mail Email

Parent or other Responsible Party if other than patient
Legal Name_____ Date of Birth_____
(Last) (First) (Middle)

Mailing Address_____
Home Phone_____ Work Phone_____ Cell Phone_____
Social Security #_____ Sex: M / F Marital Status: S / M / D / W
Employer_____ City_____

Insured Information if Insured Is Not Patient nor Responsible Party
Insured's Name_____ Date of Birth_____
Insured's Social Security #_____
Insured Phone Number_____ Employer_____

Notice of Privacy Practices: I acknowledge I have been offered a copy of Robert A Davis MD Notice of Privacy Practices
Signature_____
(please sign this at check in where you will be given a copy of our Notice of Privacy Practices)

I authorize the staff at Dublin Medical to discuss my medical information with the following persons. This authorization shall remain in effect until such time as it is withdrawn by me in writing.
_____Relationship _____ Phone_____
_____Relationship _____ Phone_____
_____Relationship _____ Phone_____

Emergency Contact Information (must be someone listed above)

Name_____ Phone number(s)_____

Patient Signature: _____ Date: _____