DUBLIN MEDICAL CENTER
Family Medicine

Patient Information

Patient Information

Last Name	First Name	Middle Initial	Previous Name (If applicable)

Date of Birth	Sex	Social Security #
	☐ Male ☐ Female ☐ Decline	

Marital Status	Spouse Name	Spouse DOB
☐ Single ☐ Married ☐ Divorced ☐ Other		

Race
☐ White ☐ Black or African American
☐ Asian ☐ American Indian / Alaskan Native
☐ Native Hawaiian / Pacific Islander
☐ Prefer not to answer ☐ Other

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Decline to Answer

Preferred Language
☐ English ☐ Español ☐ Other _____

Employer	Occupation

Contact Information

Mailing Address	Apt #	City	State	Zip Code

Cell Phone ☐ Preferred	Home Phone ☐ Preferred	Work Email ☐ Preferred

Email Address	Preferred Contact Method	Can we leave you a voice message?
	☐ Phone ☐ Email ☐ Mail	☐ Yes ☐ No

Insurance

Primary Insurance		Secondary Insurance	
Insurance Company Name		Insurance Company Name	
Policy Holder Name		Policy Holder Name	
Policy Name / Member Id	Group Id	Policy Name / Member Id	Group Id
Policy Holder DOB	Policy Holder SS#	Policy Holder DOB	Policy Holder SS#
Patient Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Dependent		Patient Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Dependent	

Parent / Guardian / Responsible Party (If other than patient)

Last Name	First Name	Middle Initial	Relationship to Patient

Date of Birth	Sex	Social Security #
	☐ Male ☐ Female ☐ Decline	

Mailing Address	Apt #	City	State	Zip Code

Cell Phone	Home Phone	Work Email
☐ Preferred	☐ Preferred	☐ Preferred

Emergency Contact

Contact Name	Relationship to Patient	Phone Number

I hereby authorize Robert A Davis, MD Family Practice to discuss and or release my PHI (protected health information) to:

☐ Do not discuss my health with anyone but me or my designated responsible party.

Contact Name	Relationship to Patient	Phone Number

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Robert A Davis, MD Family Practice and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Robert A Davis, MD Family Practice.

I authorize the payment of medical benefits to Robert A Davis, MD Family Practice or their designated partner for services rendered.

I have received a copy of both the Notice of Privacy Policy, Financial Policy, and Medical Appointment Cancellation / No Show Policy.

Sign Your Name: _____ **Date:** _____

Print Your Name: _____ **Date of Birth:** _____

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