DONEN DAVIS PLASTIC SURGERY, LLC

Donen Davis, J.D, M.D.

PATIENT INFORMATION

Patient Name: ____ Date of Birth: __________________ Age: __________
(Last) (First) (Middle)

Home Address: ____ Home Phone: (_____)________________________

____ Work Phone: (_____)________________________

City/State/Zip ____ Cell/Pager: (_____)________________________

E-mail address:____ (if you would like to receive information from us)

SS#: __________________________ Gender: Male / Female Marital Status: (circle one) Single Married Divorced Widowed

Spouse Name: _____________________________ Parent's Name (if patient is a minor): _________________________________

Person to notify in an emergency: ___________________________/_______________________ Phone: (_____)_____________
Name Relationship

Patient's Employer: ____ Occupation: ________________________________

Referring Physician: _______________________________________ Primary Care Physician: ___________________________

How did you hear about us? ________________________________

INSURANCE INFORMATION - **Provide a copy of your insurance cards to the receptionist**

Primary Insurance Company: ____________________________________ Insured's Name: ________________________________

ID# or Policy #: ____________________________ Group #:__________________ Group Name/Employer: __________________

Insured's Date of Birth: _____________________________ Insured's Social Security Number: _____________________________

Secondary Insurance Company: __________________________________ Insured's Name: ________________________________

ID# or Policy #: ____________________________ Group #: __________________ Group Name/Employer: __________________

Insured's Date of Birth: ____________________________ Insured's Social Security Number: ______________________________

AUTHORIZATION TO RELEASE INFORMATION / ASSIGNMENT

I hereby authorize Donen Davis Plastic Surgery, LLC to furnish information to my Insurance carriers concerning my treatment, and I hereby assign to Dr. Donen Davis all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance. I authorize a photocopy of this assignment in lieu of the original when necessary.

____ _________________________

Patient / Responsible Party Signature Date