Lori L. Davidson, MD, FACOG

Patient Registration Form – please complete all information

Patient Name (first, middle, last): ____

Patient Address: _______________________________________

City: _______________ **State**: ___ **ZIP**: _____________

Phone – Home: ____-____-______ **Work**: ____-____-______ **Cell**: ____-____-______

Date of Birth: ___/___/_____ **SSN#** _______-______-________ **Marital Status**: ___________

Employer: _________________________________ **Status:** Full-time Part-time Retired None

Employer Address: _______________________ **City/St/ZIP:** _________________________

May we contact you at work? Yes No **If Student:** Full-time Part-time Where: ____________

Emergency Contacts: *Please list two people we have permission to contact*

Name 1: ____________________ **Relationship**: _____________ **Phone**: _____-_____-_______

Address: _____________________________________ **City/St/ZIP**: ______________________

Name 2: ____________________ **Relationship**: _____________ **Phone**: _____-_____-_______

Address: _____________________________________ **City/St/ZIP**: ______________________

Insurance Company: ___________________ **Policy/ID#** ___________ **Member**: Self Spouse Parent

Insurance Company: __________________ **Policy/ID#** ____________ **Member**: Self Spouse Parent

Family Doctor: _________________________ **How Referred to us**: ______________________

Please complete this section if you are married or your parent's are responsible for insurance coverage

Spouse or Parent Name: ________________________________ **Date of Birth**: ____/____/_____

Social Security #: _______-_______-_________ **Home Phone Number**: _____-_____-_________

Employer: ____

Employer Address: _______________________________ **City/St/Zip**: ____________________

I certify the above information to be true and accurate. I authorize my insurance company to make payment to Caring for Women's Health directly for all services rendered. I authorize the release of my medical records as necessary to process my insurance claims. I understand and agree, regardless of my insurance status, I am responsible for the balance of my account. I am aware and agree there will be a monthly finance charge of 1.5% on any unpaid balances of 90 days and over. I designate your office, employees, and agents as my representatives to file grievances in accordance with Indiana Code, Title 27, Chapters 8 and 13.

_____________________________________ **Today's Date**: _____/______/______

Patient/Responsible Party Signature

Payment is expected at the time of service

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