Name_____ Date_____

Address_____City_____State_____Zip_____

Home phone ( )_____ Cell phone ( )_____Work phone ( )_____

Social Security #_____ Drivers License #_____

Occupation_____Employer_____

Email_____ Married Single Divorced Widowed Living w partner

Would you like results by email? YES NO

Preferred Language English Spanish Other_____

Race Afr/Afr Am Caucasian/Euro Asian/Asian Amer Native Am/Alaska Hawaii/Pacific Other Decline to state

Ethnicity Hispanic Non Hispanic

Emergency Contact _____ Relationship _____ Phone ( )_____

Primary care physician _____

Whom may we thank for referring you? _____ (Physician name)

Reason for today's visit Well visit Pregnancy Medical problem

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH _____ (Insurance company)

AND ASSIGN DIRCTLY TO MARY L DAVENPORT, MD, ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE WITHIN 120 DAYS FROM DATE OF SERVICE, I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS.

I GIVE MY PERMISSION FOR MARY L DAVENPORT, MD, TO TREAT ME FOR ANY AND ALL ILLNESSES THAT PERTAIN TO MY CARE.

Signature _____ Date _____

I acknowledge that I have received the Patient Notice of Privacy Practices.

Signature_____ Date _____

I request the following restrictions to disclosure of my health information.

Medical information can be shared with:

(Circle) Patient only Family members of friend Physicians Other _____