Davis Consultants, PC

Patrick Davis, Ph.D. Suzanne Richards, LCSW

CLIENT/EXAMINEE REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	Marital Status:
Birthdate:	Age:	Gender Identification: ❒Male ❒ Female	Other: _____

Address:

Social Security Number:	Home Phone Number:	Cell Phone Number:
Occupation:	Employer:	Employer Phone Number:

Chose clinic because/referred to clinic by:

Other family members seen here:

INSURANCE INFORMATION

If Your Insurance is **Workers Compensation**, please share your official **Date of Injury:**

Person responsible for bill:	Birth Date:	Address:	Home Phone Number:
Occupation:	Employer:	Employer Address:	Employer Phone Number:

Name of Primary Insurance Company:

Subscriber's Name:	Subscriber's Social Security Number:	Subscriber's Birth Date:	Group Number:	Policy Number:

Client's relationship to subscriber:

Name of Secondary Insurance (if applicable):	Subscriber's Name:	Group Number:	Policy Number:

Client's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home Phone Number:	Work Phone Number:

My signature below signifies my agreement with the following statements:

- The above information is true to the best of my knowledge.
- I authorize my insurance benefits be paid directly to Davis Consultants, PC.
- I understand that unless otherwise agreed I am financially responsible for any balance.
- I authorize Davis Consultants, PC to release any information required to process my claims.

Signature _____ Date _____

Rev: 09 16 2016