GLENA DAVIS, D.O.
OBSTETRICS/GYNECOLOGY

INSURANCE ASSIGNMENT

If you have an insurance card, please sign below and we will copy your card for this information

Insurance Company _____ Phone Number _____

Group # _____ Certificate or ID # _____

Insured's Name _____ Relationship to Patient: ❑Self❑ Spouse ❑Dependent

Insured's Employer _____ Phone Number _____

Employer Address_____

Insured's Social Security # _____ Date of Birth _____ ❑Male ❑Female

I hereby assign, transfer, and set over to **Glena Davis, D.O**. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature_____ Date _____

Parent/Guardian Signature if Patient is a minor _____

Relationship to Patient _____