# DR. GLENA J. DAVIS
# OBSTETRICS/GYNECOLOGY
# PATIENT REGISTRATION

*Please print clearly so that we can process your information quickly and efficiently. Thank you!*

**Name** (*First, M.I.,Last)*___________________________________________________**Date of Birth** _____________

**Address** ______________________________________________________________________________________

**Phone Number** _______________ **Social Security #** __________________ Driver's License #________________

**Marital Status**: ❑ S ❑ M ❑ W ❑ D

**Race**: ❑White ❑ Hispanic ❑Native American ❑Asian or Pacific Rim ❑Black or African American ❑Other ❑Do not wish to report

**Ethnicity**: ❑ Hispanic or Latin ❑ Not Hispanic or Latin ❑ Do not wish to report

**Language Preference**: ❑ English ❑ Other ❑ Indian (includes Hindi & Tamil) ❑ Spanish ❑ Russian

For prescriptions, which pharmacy do you prefer? ❑ Waddy's ❑ Diamond's ❑Wal-Mart ❑CVS ❑Walgreens

Employer _________________________________________________________ Phone _______________________

Employer Address ___________________________________________________________________________

Referring Physician __________________________________________________________________________

If Student, School Name ____________________________________________________ ❑ Full-Time ❑Part-Time

I hereby give my permission for any confidential information regarding my records with your office to the following people:_________________________________________________________________________________

**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 ___________________________________________________________________________

**EMERGENCY CONTACT INFORMATION**

Emergency Contact _________________________________________________ Phone Number __________________