Patient Demographics & Insurance

Karla Davidson-Cox, MD

Acct #

Patient Information

Patient Last Name	First Name	Middle Name	
Address	City	State	Zipcode
Home/Cell Phone (Please indicate):	Work Phone		
Social Security Number	Sex: Male Female	Date of Birth	
Marital Status: Single Married Divorced Separated Widowed	E-mail (Allows us to send you important messages)		
Employer Name	Employer Address		
How did you hear about the physician you are seeing today? Friend or Family member, Insurance plan, Digital/Web advertising, Mailer/Postcard, Physician referral: _____ Other: _____			

Complete this section only if the patient above is a minor:

Responsible Party

Responsible Party Last Name	First Name	Middle Name	
Address	City	State	Zipcode
Home/Cell Phone	Work Phone		
E-mail (Allows us to send you important messages)	Marital Status: Single Married Divorced Separated Widowed		

Insurance and Subscriber Information

Primary Insurance Company	Effective Date		**Secondary** Insurance Company	Effective Date	
Claims Mailing Address			Claims Mailing Address		
City	State	Zipcode	City	State	Zipcode
Policy ID Number	Group ID Number		Policy ID Number	Group ID Number	
Subscriber Name (policy holder)	Date of birth		Subscriber Name (policy holder)	Date of birth	
Subscriber Social Security #	Relation to Patient		Subscriber Social Security #	Relation to Patient	
Subscriber Employer	Work Phone		Subscriber Employer	Work Phone	
Subscriber Employer Address			Subscriber Employer Address		
City	State	Zipcode	City	State	Zipcode

Completed by: _____ Date: _____