

Davenport Surgical Group

1228 E Rusholme Suite 302
Davenport, IA 52807
(563) 823-9330

PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		Pharmacy Info			
CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE		
PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN			
PRIMARY EMPLOYER		SECONDARY EMPLOYER (if Applicable)			
ADDRESS		ADDRESS			
CITY, STATE ZIP		CITY, STATE ZIP			
WORK PHONE		WORK PHONE			

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)		
CITY, STATE ZIP		CITY, STATE ZIP		
HOME PHONE		HOME PHONE		
RELATIONSHIP TO PATIENT				

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#		
NAME OF INSURED		GROUP#		
ADDRESS OF INSURANCE COMPANY		COPAY AMT		
		\$		
CITY, STATE ZIP		DEDUCTIBLE		
		\$		
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#		
NAME OF INSURED		GROUP#		
ADDRESS OF INSURANCE COMPANY		COPAY AMT		
		\$		
CITY, STATE ZIP		DEDUCTIBLE		
		\$		
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE	

I hereby authorize the release of any information necessary to determine liability for payment and to obtain reimbursement of any claim. This authorization includes any physician, hospital, or other medical provider to release pertinent medical information to or from DAVENPORT SURGICAL GROUP, P.C.

Please remember that insurance is considered a method of reimbursing the patient for fee paid to the doctor and is not a substitute for payment. It is your responsibility to pay any balances remaining after your insurance has paid.

SIGNATURE OF PATIENT/GUARDIAN

DATE