Lori L. Davidson, MD, FACOG

Caring for Women's Health

Thank you for updating your information!

No changes? Write N/C in section

Name	Home Phone
Address	Cell Phone
City, State, Zip	E-Mail
SSN:	Date of Birth / /
Mail Statements Here? ☐ Yes ☐ No	**Marital Status?** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Work Status? ☐ Full-time ☐ Part-time ☐ Not Employed ☐ Retired	Work Phone
Employer	OK to Contact at work? ☐ Yes ☐ No
If Student, Where?	If Student, Status: ☐ Full-time ☐Part-time
We may leave appointment reminder messages at which of these locations. Check your preference: ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email ☐Work Phone	
Referred to Dr. Davidson by ☐ Friend ☐ Parent ☐ My Doctor ☐ Search Online ☐ Other_____	

Emergency Contact 1	Relationship	
☐ Granted Full Personal Health Information Access	☐ May pickup medications	Phone
Emergency Contact 2	Relationship	
☐ Granted Full Personal Health Information Access	☐ May pickup medications	Phone

Family Doctor

First	Last	City, State

Insurance Information

Insurance Carrier	**If TRI-CARE SSN Required**	
Member ID#	Group#	Plan Code

Guarantor – *Please complete if **YOUR NAME is NOT** on the insurance card or if you are NOT the responsible party*

Name	**IMPORTANT: Date of Birth**
Address	**Guarantor's SSN:**
City, State, Zip	
Phone	Relationship

I certify the above information to be true and accurate. I authorize my insurance company to make payment to Caring for Women's Health directly for all services rendered. I authorize the release of my medical records as necessary to process my insurance claims and to the contacts listed above if so indicated. I understand and agree, regardless of my insurance status, I am responsible for the balance of my account. I designate your office, employees, and agents as my representatives to file grievances in accordance with Indiana Code, Title 27, Chapters 8 and 13.

_____ _____

Patient/Guardian/Guarantor Signature **Today's Date**