ELIZABETH COVINGTON, M.D., Inc.

PATIENT INFORMATION

Name: Date of Birth: Sex: M / F

Phone #: Social Security #: Marital Status: S M W D

Address: (City) (State) (ZIP)

Employer: Work Phone #:

Employer's Address: (City) (State) (ZIP)

Referring Source: ___Yellow Pages ___Physician ___Friend/Patient ___Provider Book ___Lecture ___Other________

Race: ___Black ___Caucasian ___Hispanic ___Asian ___Other

SPOUSE/RESPONSIBLE PARTY INFORMATION

Name: Date of Birth: Sex: M / F

Phone #: Social Security #: Relationship to Patient: Spouse/Patient/Other

Address: (City) (State) (ZIP)

EMERGENCY CONTACT INFORMATION

Name: Date of Birth: Sex: M / F

Phone #: Social Security #: Relationship to Patient: Spouse/Patient/Other

PRIMARY INSURANCE INFORMATION

Name: Group #: ID #:

Phone #: Insurance Address:

Insured's name: Date of Birth: Sex: M / F

Insured's Social Security #: Relationship to Patient: Spouse/Patient/Other

SECONDARY INSURANCE INFORMATION

Name: Group #: ID #:

Phone #: Insurance Address:

Insured's name: Date of Birth: Sex: M / F

Insured's Social Security #: Relationship to Patient: Spouse/Patient/Other

I authorize the release of any medical information needed to determine those benefits. I Authorize ALL payments to be made directly to Elizabeth Covington, M.D., Inc. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges, including Deductibles and Copayments, whether or not they are covered by insurance. I further understand that I may be charged interest at a rate of 19.5% per annum, for all balances not paid upon monthly.

Patient's Signature Date