Patient Information

Name: (Last) _____ (First) _____ (MI) _____

Home Address: _____

City: _____State:_____Zip:_____

Home Phone: _____ Work Phone: _____Cell Phone_____

Email Address: _____Preferred method of contact_____

Social Security #:_____ Date of Birth: _____

Your Employer: _____ Occupation: _____

Employer's Address: _____

City: _____State:_____Zip:_____

Circle One: Single Married Separated Divorced Widowed

Spouse: _____ Work Phone: _____

Employer: _____

Address: _____

Are you allergic to any medication? YES _____ NO _____

If YES, list medications: _____ _____ _____

_____ _____ _____ _____

Your Primary Care Physician: _____ Phone #:_____

Address: _____

If the patient is a minor, Please list names of parents:

Father: _____ Work Phone: _____

Home Address and Phone #, if different: _____

_____

Mother: _____ Work Phone: _____

Home Address and Phone #, if different: _____

Insurance Information

Primary Insurance Company: _____ Effective Date: _____

Address: _____

Name of Insured: _____ ID#: _____

Insured's Date of Birth: _____ Relationship: _____

Secondary Insurance Company: _____Effective Date: _____

Address: _____

Name of Insured: _____ ID#: _____

Insured's Date of Birth: _____ Relationship: _____

Name of relative or friend not living with you: _____

Address of same person: _____

Phone number of same person: _____Relationship: _____

I authorize Dr. Graham Smith to release information regarding my diagnosis and treatment to my insurance company and/or attorney.

Signature: _____ Date: _____

I certify that this information is true and correct to the best of my knowledge. I will notify this office of any changes on the information I have provided by means of this form.

I understand that I am ultimately responsible for the balance on my account not covered by insurance for any professional services rendered unless this is a valid covered Workman's Comp Claim.

Signature: _____ Date: _____

Signature on File

I authorize payment directly to my doctor. I authorize release of information to all my insurance companies. I permit a copy of this signature to be used in place of the original.

Name (Please Print): _____

Signature: _____ Date: _____