



Patient Information Form
Please Print Clearly

Patient First Name: _____ MI _____ Last Name: _____
If patient is a minor: Guardian's Full Name: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Birth Date: ___/___/___ Sex: ___ Social Security: ___-___-___
Home Phone: (___) _____ Work Phone: (___) _____ Ext: _____
Cell Phone (___) _____ Email address: _____
Marital Status Single: ___ Married ___ Widowed: ___ Divorced: ___
If married full name of spouse: _____
Emergency Contact: _____ Phone Number: (___) _____
Relationship to Patient: _____

How did you learn about us?
___ Billboard ___ Mailing ___ Newspaper ___ Radio Ad ___ Family Doctor
___ Brochure ___ Newsletter ___ Website ___ A Friend

Name of Physician who referred you to our office: _____
Name of your Primary Care Physician: _____

Insurance Information

Primary Ins. Company _____ Secondary Ins. Company _____
ID / Policy #: _____ ID / Policy #: _____
If other that the patient please list:
Name of Cardholder _____ Name of Cardholder _____
Birth Date of Cardholder: _____ Birth Date of Cardholder: _____
SSN #: _____ SSN #: _____

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S) FOR COPYING.

AUTHORIZATION – PLEASE READ BEFORE SIGNING

I, _____, hereby authorize WENDY L. SMITH, M.D., her authorized agents, and/or any agent acting on the insurance carrier's behalf to process my medical claims for payment. I understand that these records may include information regarding my physical or mental condition and treatment including drug or alcohol information and treatment records. I authorize the release of such records and/or information to my insurance carrier and/or any agent acting on the insurance carrier's behalf, my family (if authorized above), my primary care physician, or other treating physician.

I hereby assign to WENDY L. SMITH, MD, all payments for medical services rendered to myself and/or my dependants, and I understand and agree that any services not covered by my insurance company are my responsibility to pay. I understand and agree to pay a finance charge of 1.5% per month should my balance become older than 30 days. Furthermore, I understand and agree to pay reasonable collection charges and or attorney fees in the event that I am in default of payment.

I understand that I must pay my co-pay and any deductible that has not been met at the time of my visit.

I understand and agree to pay a \$25 missed appointment fee if I fail to give at least a 24 hour advanced noticed. I understand and agree to pay a \$25 fee for all returned checks.

Initial here: ___ if we have your permission to discuss your medical information with your immediate family members.

SIGNATURE OF [Check one that applies] _____ DATE _____
___ Patient ___ Parent ___ Legal Guardian (Provide Proof of Guardian ship)