Dr. Paul Grayson Smith, Jr., D.O. • Dr. Paul Grayson Smith, III, D.O.
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How did you hear about our office?

☐ Facebook ☐ Google Search ☐ Instagram ☐ Friend or Family Member ☐ Word of Mouth ☐ Doctor's Office

Referred By:_____ Are they a patient here? ☐ YES ☐ NO

PATIENT INFORMATION

PATIENT NAME: _____HOME PHONE:_____
(Last, First, MI)

ADDRESS: _____
(Street) (Apt. #) (City) (State) (Zip)

SEX: ☐ M ☐ F MARITAL STATUS: ☐ S ☐ M ☐ W ☐ D SSN: _____ LANGUAGE: _____

DATE OF BIRTH: _____ AGE: _____ CELL PHONE: _____ ETHNICITY: _____

EMAIL: _____RACE: _____

EMPLOYER:_____
(Company) (Address) (Phone)

SPOUSE:_____
(Name) (DOB) (SSN)

SPOUSE EMPLOYER: _____ PHONE: _____

NEAREST CONTACT NOT LIVING WITH YOU? NAME: _____

ADDRESS: _____PHONE: _____

PHARMACY NAME AND ADDRESS:_____

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR PATIENTS UNDER AGE 18:

FATHER: _____ MOTHER: _____
ADDRESS: _____ ADDRESS: _____
EMPLOYER:_____EMPLOYER:_____
SSN:_____DOB:_____SSN:_____DOB:_____

INSURANCE INFORMATION – PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST

PRIMARY INSURANCE: _____SECONDARY INSURANCE: _____
Payments for services rendered that are not billed to insurance, co-payment amount, deductible, and patient percentages are expected at the time services are rendered. If necessary, arrangements for payments should be made before services are rendered.
INSURANCE AUTHORIZATION AND ASSIGNMENT. I hereby authorize Dr. Paul Grayson Smith, JR., D.O., P.C. to furnish information to insurance carriers concerning my illness and treatments. I hereby assign to the providers all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount for services rendered and/or not covered by insurance. Failure to pay will result in legal counsel and collections. I understand that I am responsible for any attorney fees and collection costs that will be incurred in such an attempt to collect this debt.
RELEASE OF MEDICAL INFORMATION (Please check all that apply.)
If I am unable to be reached by Dr. Paul Grayson Smith, JR., D.O., P.C. regarding any test results, labs, appointments, insurance or billing questions, and/or any other information that this office is trying to reach me about:
_____ I authorize any messages to be left on my answering machine.
_____ I authorize information to be given to (list specific names): _____

_____ I wish to be contacted by mail only.

SIGNATURE: _____ **DATE:** _____
Patient/Responsible Party

OFFICE USE: UPDATED BY_____DATE: _____