

**Gary A. Smith, MD, PLLC**

**Tracy L. Jones, MS, PA-C**

New Patient

Date: \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

Male

Female

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SSN \_\_\_\_\_  Single  Married  Divorced  Widowed

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_ S.S.# \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY \_\_\_\_\_ SECONDARY \_\_\_\_\_

ADDRESS \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ PHONE \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_ POLICY HOLDER \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

POLICY #1 \_\_\_\_\_ GROUP # \_\_\_\_\_ POLICY #2 \_\_\_\_\_ GROUP # \_\_\_\_\_

I hereby authorize the release of any information acquired in the course of my examination for treatment to the insurance carrier listed above.

Date \_\_\_\_\_ Signature \_\_\_\_\_ Witness \_\_\_\_\_

**FINANCIAL AGREEMENT**

The financial policy of my health care provider has been fully explained to me and I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I hereby authorize my health care provider to obtain on my behalf, any insurance information covered by "the Privacy Act" from my insurance company file. I hereby authorize payment directly to the physician for medical and/or surgical benefits.

Date \_\_\_\_\_ Signature \_\_\_\_\_ Witness \_\_\_\_\_