PATIENT DEMOGRAPHIC FORM
Jeffrey D. Smith, M.D., P.C.

Patient Name _____ Sex : Female/Male

Address _____ City_____ State____

Zip _____ D.O.B_____ Social Security #_____

Home Phone _____ Work Phone _____

Email Address:_____ Pharmacy & phone:_____

Please identify an emergency contact that we would be able to notify in case of an urgent situation. If patient is a child or dependent, please complete the following with the parent/guardian information.

Emergency Contact/Parent/Guardian _____

Phone Number Daytime and Evening _____/_____

For Billing purposes, we must have the following information

Primary Care Physician _____ Phone_____

Address _____

Dermatologist_____Phone_____

Address_____

A COPY OF YOUR INSURANCE CARD DOES NOT REPLACE OUR NEED FOR THE FOLLOWING:

Insurance Company _____ Referrals Required? ___Y ___N

Insurance ID # _____ Group # _____

Subscriber's Name _____ Date of Birth _____

Subscriber's Social Security # _____ Employer_____

Other INSURANCE Coverage? _____

Relationship of patient to subscriber: (please circle) Patient Spouse Child Dependent Other

WORKMEN'S COMP OR MVA CLAIMS ONLY: Date of Accident/Injury: _____ Claim # _____

Employer _____ Employer's Phone # _____

Has this been reported to your employer or insurance company? _____ Y _____ N

I authorize the release of any health information necessary to process claims. I authorize payment of health care benefits to the provider that rendered the services if payment is denied, I am responsible for payment.

SIGNATURE _____ DATE _____

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