Dr. Keith Smith
901 Leighton Ave Suite 705, Anniston, AL 36207
Phone: (256) 231-1322 Fax: (256) 231-1324

Revised 04/27/17

Today's Date: ____________________

Referring Doctor: ____________________

PATIENT REGISTRATION FORM

Primary Medical Doctor (if different): ____________________

Last Name: ____________________ First Name: ____________________ Middle Name: ____________________

Name you prefer to be called: ____________________ DOB: ____________ Sex: MALE FEMALE

SSN: ____________________ Marital Status: ____________ Race or Ethnicity: ____________

Address: ____

City: ____________________ State: ____________ Zip Code: ____________

Home Phone: ____________ Work Phone: ____________ Mobile Phone: ____________

May we leave a message at the above phone numbers? ________

May we contact you concerning appointments by email? ________ Email Address: ____________________

Employer: ____________________ Occupation: ____________________

Responsible Party/ Legal Guardian: ____________________ DOB: ____________

INSURANCE

#1 Insurance Co: ____________ Policy # ____________ Group # ____________

Name of Policy Holder: ____________________ Relation: ____________

Policy Holder's DOB: ____________ SSN: ____________

#2 Insurance Co: ____________ Policy # ____________ Group # ____________

Name of Policy Holder: ____________________ Relation: ____________

Policy Holder's DOB: ____________ SSN: ____________

Emergency Contact

Name: ____________________ Phone: ____________ Relationship: ____________

Medical Information Disclosure

I have received, read, understand, and agree with the Notice of Privacy Practice form and authorize Dr. Keith Smith to release information pertaining to my medical care to the following:

Name: ____________________ Phone: ____________ Relationship: ____________
Name: ____________________ Phone: ____________ Relationship: ____________
Name: ____________________ Phone: ____________ Relationship: ____________

By signing this document, I acknowledge that I or my patient representative have received, read, understand, and agree with all the terms and information contained in the **Notice of Privacy Practice, Consent to Treatment**, and **Consent to Use and Disclose Protected Health Information** forms provided by Dr. Keith Smith. I, also agree that the information provided above and answers regarding my medical history are true and complete to the best of my knowledge.

____________________ Signature of Patient ____________________ Name of Patient ____________ Date

____________________ Signature of Patient Representative ____________________ Name of Patient Representative ____________ Date

Reason for Representation: ____