JOSEPH C. SMIDDY, M.D., P.C.

PATIENT INFORMATION AND DISCLOSURES

Name:_____
last first middle initial

Phone#: Home(_____)_____ Business(_____)_____

Cellular(_____)_____ E-mail Address_____

Home Address: _____ Apt_____

City:_____ State:_____ Zip:_____ County:_____

Social Security#_____ Date of Birth_____

Sex: Male_____ Female_____ Race:_____

Marital Status: Divorced_____ Married_____ Partnered_____ Single_____ Widowed_____

Employer:_____ Occupation:_____

Employer Address: _____

Emergency Contact:_____ Relationship:_____

Address: _____

City:_____ State:_____ Zip:_____

Phone: Home (_____)_____ Other: (_____)_____

Referred by:_____

PAYMENT INFORMATION

PAYMENT/COPAYMENT IN FULL IS EXPECTED AT THE TIME WHEN SERVICES ARE RENDERED. How will you pay for your visit today?
_____Personal Check _____Credit Card _____Cash

Please provide your insurance card and identification to the receptionist for verification.

An interest rate of 15% per month will be due upon all accounts more than thirty days past due. All delinquent accounts will be subject to payment of costs of collection, including reasonable attorney's fees in the amount of 15% of your unpaid balance. By signing below and accepting services from us, you will be agreeing to these terms.

Signature:_____

Date: _____