

PATIENT INFORMATION FORM

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Family Practice

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ABOUT INSURANCE & FEES

Our office welcomes insurance, but payment is expected at the time of service for all Deductibles, Co-Pays and Co-Insurance. Our office accepts credit cards for your convenience. Whenever you request us to render a service there will be a CHARGE to you or your insurance company. When you have urgent need, but we cannot accommodate you for an office visit, a telephone consultation may be done to render immediate treatment. The rate for this service is \$3.00 per minute. This will be put on our schedule and a bill will be generated for the services provided. We will always attempt to forward these charges to your insurance company. For Self-Pay patients, a menu of service charges is posted at our front desk.

DATE:		SOCIAL SECURITY NUMBER		REFERRED BY:	
NAME:	LAST	FIRST	MIDDLE	HOME PHONE:	
ADDRESS:		CITY:	STATE:	ZIP:	

MAY WE HAVE YOUR E-MAIL ADDRESS SO THAT WE CAN SEND YOU PERSONAL INFORMATION, SUCH AS TEST RESULTS? Yes or No E-MAIL ADDRESS:

SEX M / F	AGE:	D.O.B.	MARITAL STATUS: M S W D	NUMBER OF CHILDREN:
YOUR OCCUPATION:		YOUR EMPLOYER:		YOUR SUPERVISOR
YOUR EMPLOYER'S ADDRESS:		CITY, STATE, ZIP		EMPLOYER'S PHONE
EMERGENCY CONTACT NAME:		RELATIONSHIP	PHONE:	
NAME OF PARENT / GUARDIAN (if patient is a minor):			RELATIONSHIP	

IF YOU HAVE INSURANCE, PLEASE FILL OUT THE FOLLOWING:

INSURED'S NAME:		INSURED'S SOC. SEC. #	INSURED'S D.O.B.
INSURED'S EMPLOYER'S ADDRESS:		CITY, STATE, ZIP	EMPLOYER'S PHONE

PLEASE LIST ANY ADDITIONAL MEMBERS ON INSURED'S CARD

NAME	RELATION	SOCIAL SECURITY #	D.O.B.
NAME	RELATION	SOCIAL SECURITY #	D.O.B.
NAME	RELATION	SOCIAL SECURITY #	D.O.B.
NAME	RELATION	SOCIAL SECURITY #	D.O.B.

PLEASE OFFER A COPY OF YOUR INSURANCE CARD TO THE FRONT DESK.