Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

STEVEN J. SMITH, M.D., PLLC

Specializing in Aesthetic Surgery

AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY

Patient Registration Form

PATIENT INFORMATION - (PLEASE PRINT)

LAST NAME	FIRST NAME	MIDDLE NAME

ADDRESS	CITY	STATE	ZIP

HOME TELEPHONE ( )	CELL PHONE ( )	BIRTHDATE	AGE	SS#

EMAIL ADDRESS:

MARITAL STATUS: (Please Circle) MARRIED/ SINGLE/ DIVORCED / WIDOWED	SEX: MALE /FEMALE

IF PATIENT MINOR – PARENTS NAMES	ADDRESS OF GUARANTOR IF DIFFERENT THAN ABOVE

EMPLOYMENT STATUS: (Please Circle) EMPLOYED/ RETIRED/ FULL TIME STUDENT/ PART TIME STUDENT

PATIENTS EMPLOYER	POSITION

EMPLOYERS ADDRESS	WORK TELEPHONE

REFERRAL SOURCE (Patient/Other) Patient Name: _____ Other: _____

IN CASE OF EMERGENCY, PERSON TO CONTACT	TELEPHONE ( )	RELATIONSHIP TO PATIENT

INSURANCE AND BILLING INFORMATION – (PLEASE COMPLETE)

INSURANCE CO. NAME	ADDRESS	

POLICY OR ID#	GROUP #	EFFECTIVE DATE

NAME OF PERSON HOLDING INSURANCE	BIRTHDATE	RELATIONSHIP TO PATIENT

IS THIS POLICY AN INDIVIDUAL PLAN OR EMPLOYER SPONSORED? (Please Circle) INDIVIDUAL / EMPLOYER SPONSORED

EMPLOYER NAME:_____

1) AGREEMENT AND CONSENT: I HEREBY AUTHORIZE MEDICAL SERVICES TO BE PROVIDED TO ME/MY CHILD (FOR WHOM I AM THE PARENT OR LEGAL REPRESENTATIVE AND AM AUTHORIZED TO ACT ON HIS/HER BEHALF) BY Steven J. Smith M.D., and staff of Steven J. Smith, M.D., PLLC.

2) ASSIGNMENT OF INSURANCE BENEFITS: I authorize and request that payment be made directly to Steven J. Smith, M.D., PLLC for any insurance benefits payable for services provided to me/my child by Steven J. Smith, M.D., PLLC. This authorization expressly included any benefits that are to be provided by TennCare and any other public or private insurance plans. This request will remain in effect until revoked by me in writing.

Signature:_____ Date:_____

Relationship to Patient: _____ 07/10

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www.stevenjsmithmd.com

Health History Form

PATIENT NAME:	PHONE:	DATE:	CHART#

Drug Allergies: Circle all that apply. ---→ Penicillin Sulfa Erythromycin Aspirin Tetracycline

Antihistamines Codeine Ibuprofen Other(s):

Have you ever been treated for or had any known indications of:

	YES	NO		YES	NO
HEART TROUBLE			DIABETES OR SUGAR IN URINE		
HIGH BLOOD PRESSURE			CANCER		
ABNORMAL PULSE			ARTHRITIS		
LUNG OR RESPIRATORY TROUBLE			LIVER OR GALLBLADDER DISORDER		
STOMACH OR INTESTINAL TROUBLE			NEURITIS OR SCIATICA		
SPINE OR BACK DISORDER			KIDNEY,BLADDER,URINARY SYSTEM		
NERVOUS DISORDER			SEIZURES OR CONVULSIONS		
BLEEDING DISORDER			OTHER:		

HEIGHT AND WEIGHT:

CHILDREN:

PRIMARY CARE PHYSCIAN:

LIST PAST HOSPITALIZATIONS/SURGERIES (REASONS FOR) AND DATES:

ARE YOU CURRENTLY TAKING ANY MEDICATIONS (OTC/VITAMINS/SUPPLEMENTS)? IF SO PLEASE LIST:

FAMILY DISEASE HISTORY. LIST YOUR RELATIONSHIP TO FAMILY MEMBER AND THE DISEASE THEY HAVE/HAD:

SUBSTANCE ABUSE?

DO YOU SMOKE?	HOW MUCH?
DO YOU DRINK COFFEE?	HOW MUCH?
DO YOU DRINK ALCOHOL?	HOW MUCH?

I certify that the above is true and correct. I realize that withholding information about my medical history may result in serious injury to me or harm to those involved in my care. I am aware that providing false or incomplete information about my medical and surgical history may result in the cancellation of my proposed surgical procedure and also result in forfeiture of my surgical fees.

_____ _____

Patient Signature Date

_____ _____

Practice Representative Date