Michael K. Smith, M.D.

Registration Sheet

Date:_____

Patient Last Name:_____First:_____MI:_____

Date of Birth: _____/_____/_____ Age:_____ SSN: _____-_____-_____

Mailing address:_____

City _____State_____Zip_____

Home phone: (_____)_____-_____ May a message be left at this number?___yes ___no

Work phone: (_____)_____-_____ May a message be left at this number?___yes ___no

Cell phone: (_____)_____-_____ May a message be left at this number?___yes ___no

Pager: _____

How do you prefer to be contacted? _____

Would you like to receive invoices &/or statements via email? ___yes ___no

Email address (to be used for billing purposes only): _____

Referred by: _____

In case of emergency, contact:

Name: _____ Relationship: _____

Contact number(s): _____