J. Robert Smyer, M.D.
Patient Registration

Section A: Patient Information

PLEASE PRESENT A COPY OF YOUR CURRENT INSURANCE CARD.

Patient's Legal Name: First _____ MI _____ Last _____

Address _____ City _____ St _____ Zip _____

Telephone (H) _____ (W) _____ (C) _____

E-mail Address _____ Date of Birth _____ Sex F M

Marital Status _____ Social Security Number _____ Driver's License _____

Employer's Name _____ Telephone _____

Address _____ City _____ St _____ Zip _____

Emergency Contact Name _____ Phone _____ Relation _____

Section B: Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the J. Robert Smyer, MD Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

_____ _____

Signature of Patient (or Patient's Representative) Date

_____

Relationship to Patient

For Office Use Only

If patient/patient representative refuses to sign acknowledgment, please document date and time the notice was presented to patient and sign below.

[ ] Presented in person (date and time) _____

[ ] Mailed (date) _____

By (name and title) _____

Patient's Name _____

DOB _____ ACCT # _____

File in patient's medical record and enter in e-MDs (must be retained for six years).