Richard F. Smith, D.O.

15 The Parkway
Katonah, NY 10536
(914) 232-5955

Patient Registration

Today's Date: _____

Please complete both sides of this form.

Personal Information

Patient Name: _____ Birth Date: _____

Address: _____ Age: _____

City, State, ZIP: _____ Soc. Sec. #: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Who referred you? _____

Sex ☐ Male ☐ Female

Email: _____

Emergency contact: _____ Emerg. Ph. #: _____

Relationship to patient: _____

Primary Physician: _____ Address: _____

Phone Number: _____ City, State, ZIP: _____

Is this the result of a:

Motor Vehicle Accident? ☐ Yes ☐ No

Work Accident or Injury? ☐ Yes ☐ No

Other Accident? ☐ Yes ☐ No

Is there a lawsuit pending regarding your medical condition? ☐ Yes ☐ No

Are you on disability? ☐ Yes ☐ No

For Adult Patients: Mobile Phone:

Home Phone: _____ Employer: _____

Work Phone: _____ Occupation: _____

For Pediatric Patients: (Complete only items different from patient's information above.)

Mother: _____ Father: _____

Address: _____ Address: _____

City, State, ZIP: _____ City, State, ZIP: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Employer: _____ Employer: _____

Occupation: _____ Occupation: _____

Who is responsible for medical bills? _____

Birth History: ☐ Normal delivery ☐ Cesarean Section because of: _____

☐ Vacuum assisted ☐ Forceps

Gestational age at birth: _____ Durationof Labor: _____ Days in hosp. _____

Complications during pregnancy (diabetes, infection, etc.): _____

_____

Complications at birth (cord around neck, resuscitation, intubation, jaundice, infection, etc.): _____

_____

Richard F. Smith, D.O.

15 The Parkway
Katonah, NY 10536
(914) 232-5955

Medical History Name: _____

REASON FOR TODAY'S VISIT:

Please list any medical conditions you now have or have had in the past (for example: asthma, diabetes, ulcers, colon cancer, Lyme disease, arthritis, etc.):

Please list all surgeries you have had, with date:

Please note all accidents, injuries, or trauma you have sustained (include falls or accidents during childhood and infancy):

Please list all medications, vitamins, minerals, herbs, homeopathics, etc. you are taking at this time:

Please list any allergies to:

Medication: _____

Food: _____

Environment: _____

I understand that I am responsible for payment for services rendered on the date of service.

_____
Signature