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:

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.): ______________________

____

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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