



Kenneth R. Smith, MD
9700 Park Plaza Ave
Bldg # 1, Suite 103
Louisville, KY 40241
(502) 429-3937

Please fill in the following and bring your insurance card to the front desk along with your copay (if applicable). Thank you.

Salutation: ___ Mr ___ Mrs ___ Miss ___ Dr ___ Ms
Title: ___ MD ___ CEO ___ DDS ___ OD ___ Other

Name: _____
___ Male ___ Female

Address: _____

City: _____ State: _____ Zip _____
Code: _____

Phone: _____ Fax: _____
Mobile: _____

SSN: _____ Age _____ DOB _____

Marital Status: ___ Married ___ Single ___ Widowed ___ Divorced

E-Mail Address: _____

Employer Name: _____
Occupation: _____

If Student, name of school: _____

Primary Care Physician: _____

Send bills to: (excluding insurance, if other than patient)

Name _____
Address _____
Relationship _____

REFERRED BY: _____
Spouse/emergency contact: _____
Relationship: _____
Emergency contact phone: _____
Emergency contact Employer: _____

Primary Insurance: _____
Policyholder's Name: _____
Policy holder's SS# _____
Policyholder's DOB _____
Policyholder's relationship to insured: _____

Secondary Insurance _____
Policyholder's Name _____
Policyholder's SS# _____
Policyholder's DOB _____
Policyholder's relationship to insured _____

**Please bring a copy of your insurance card to the front desk
I hereby acknowledge that I have received a copy of my Notice of Privacy Practices.**

Patient Signature: _____

On the line below list the individuals you would like to have access to your personal health information or write "None" if none:

Please List: _____

Medicare Lifetime Signature on file (For Medicare beneficiaries only)

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Kenneth Smith for any services furnished to me by the physician. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services. In the event that my account balance becomes delinquent or past due, I will be responsible for all collection fees, interest accrual, attorney fees, up to and including court costs.

Name: _____

Patient signature _____ Date _____

Private Insurance Signature on file

I, the undersigned, authorize payment of medical or vision benefits to Dr. Kenneth Smith for any services furnished me by the physician. I understand that I will be financially responsible for any charges not covered by my insurance contract. I authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided me. This information will be used for the purpose of evaluating and administering claims or benefits. In the event that my account balance becomes delinquent or past due, I will be responsible for all collection fees, interest accrual, attorney fees up to and including court costs.

Patient signature _____ Date: _____