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

Patient Name: ____ **SSN:** ________________________

Date of Birth: ________________ **Age:** ______ **Sex:** _____ **Marital Status:** _________________

Address: ____

City: ______________________________ **State:** _________ **Zip code:** _________________________

Phone: Home: ________________ Cell: ________________ **Email:** _____________________________

Employer: __________________________________ Occupation**:** _______________________________

Primary Care Doctor: ____________________________ Location**:** ____________________________

Pharmacy: ______________________ Location: ______________________ Phone: ______________

Send bills to (if other than patient):

Name: ____________________________________ Relationship to Patient: ________________________

Address: ____

City: ______________________________ State: _________ Zip code: __________________________

Primary Insurance: ____

Subscriber's Name: ____ SSN: ______________________

Subscriber's Date of Birth: ________________ Relationship to Insured: __________________________

Secondary Insurance: ____

Subscriber's Name: ____ SSN: ______________________

Subscriber's Date of Birth: _________________ Relationship to Insured: ________________________

Emergency Contact:

Name: _____________________________ Relationship: ______________ Phone: _________________

Please list the individuals you would like to grant access to your personal health information or write "None" if there is no one:

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