Jeffrey M. Smith, M.D.
3750 Convoy Street, Suite 201
San Diego, CA 92111
Tel: 858-278-8031
Fax: 858-278-1708
Orthopaedic Traumatologist
Board Certified in Orthopaedic Surgery

REGISTRATION INFORMATION

☐PVT ☐PPO ☐M-CAL ☐M-CARE ☐HMO ☐CHAMPUS ☐CASH   Date: ______________

Patient's Full Name: ____
Last   First   Middle

Address: ____________________ City: ______________ State: ________ Zip: ________

Hm Phone: ____________ Wk Phone: ____________ Other: ____________ Email: ______________

Marital Status: ________ Date of Birth: ________ Age: ________ Sex: ________ Social Security: ______________

Billing Address: ____________________ City: ______________ State: ________ Zip: ________

Employer: ______________________ Occupation: ______________________

Referred By: ______________ Primary M.D. ______________ Telephone: ______________

Insured Name: ______________________ Relationship to Patient: ______________________

Address: ____________________ City: ______________ State: ________ Zip: ________

Hm Phone: ____________ Wk Phone: ____________ Other: ____________ Email: ______________

Employer: ______________________ Occupation: ______________________

Address: ____________________ City: ______________ State: ________ Zip: ________

____ **Sharp Memorial EA**

Primary Insurance: ______________________ ID#: ____________ Group#: ____________

Address: ____________________ City: ______________ State: ________ Zip: ________

Telephone: ______________ Copay $: ______________________

Secondary Insurance: ______________________ ID#: ____________ Group#: ____________

Address: ____________________ City: ______________ State: ________ Zip: ________

Telephone: ______________ Copay $: ______________________

Attorney: ______________________ Telephone: ______________________

Address: ____________________ City: ______________ State: ________ Zip: ________

Emergency Contact: ______________________ Telephone: ______________________

Have you ever been seen in this practice before? Yes ☐ No ☐ By: ____________ When: ____________

I understand that patients who carry medical insurance should remember that professional services are rendered and charged to the patient, not the insurance company. In the event insurance payments are received directly by me for services rendered that have not been paid for, I promise to immediately sign over and forward those payments to the doctor. I accept financial responsibility for all charges incurred. I understand that statements are due when presented to me by Orthopaedic Trauma & Fracture Specialists Medical Corporation or when transferred to me by my insurance carrier and that a late payment charge of 1% per month applies to overdue balances. If my account has to be referred for outside collection I will be charged a service charge. AUTHORIZATION: I hereby authorize payment directly to Orthopaedic Trauma & Fracture Specialists Medical Corporation for medical services by that entity, and to release any information acquired in the course of my examination or treatment to my insurance company.

Patient's/Guardian's Signature X ______________________ Witness Signature ______________________