Center for Plastic Surgery
Dell P Smith, M.D.
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(208)735-8386 Fax (208)735-0434

How did you hear about us? **(Circle One) Phonebook Doctor Referral Friend/Family Mailer Internet TV**

Email Address_____ *This is for promotions, specials, events, etc.

Name _____DOB _____Age _____Sex _____

Address _____Phone _____

City _____State _____Zip _____SS _____

Employer _____Work # _____Cell _____

Single ___Married ___Divorced _____Widowed ___May we leave a message on your phone?_____

Spouse/ Parent Name_____

Spouse/ Father's Employer _____Work # _____

Spouse/ Mother's Employer _____Work # _____

Referring Doctor _____Family Doctor_____

Emergency contact (not in household) _____Phone #_____

Work Injury?_____ Date of Injury_____How did accident happen? _____

Other accident? _____Injury Date _____Where_____

*Primary Insurance _____Address_____

Policy # _____Group # _____Subscriber Name _____

DOB _____ Relation to Patient _____

*Secondary Insurance_____Address_____

Policy # _____Group # _____Subscriber Name _____

DOB _____ ___Relation to Patient _____

I author
release of medical information to Medicare/Medigap/ Other Third Party Payors. I authorize evaluation and treatment by Dell Smith M.D. I authorize payment of medical benefits to Dell Smith, M.D. I permit a copy of this authorization to be used in place of the original. I request that payment of authorized Medicare/ Medigap benefits be made either to me or on my behalf of Dell Smith, M.D., for any services furnished me by that physician. I authorize any holder of medical information about me to release it to Health Care Financing Administration/Medigap and its agents, any information needed to determine these benefits or the benefits payabl

We are not contracted with Humana and Blue Cross Secure Blue PPO

Signature _____ Dat _____