LaNette F. Smith, M.D.
Breast Surgery of Tulsa

PATIENT REGISTRATION FORM

Patient Name: _____ _____ _____
LAST FIRST MIDDLE

Date of Birth:_____ **Age**:_____ **Sex**:_____ **Marital Status**: _____

Address: _____ **City**:_____ **State**: _____ **Zip**:_____

Home Phone: _____ **Cell Phone**: _____ **Preferred Language**: _____

Preferred Contact: ☐ Mail ☐ Phone **E-Mail Address**: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other

Pharmacy: _____ **Address/Phone**: _____

Referring Physician: _____ **Primary Care Physician**: _____

Patient Employer: _____ **Address/Phone**: _____

Occupation: _____

Spouse Name: _____ **Date of Birth**: _____

Spouse Employer: _____ **Address/Phone**: _____

Next of Kin: _____ **Relationship**: _____ **Phone**: _____

Emergency Contact: _____ **Relationship**: _____ **Phone**: _____
(not living with you)

Primary Insurance: _____ **Employer**:_____

Policy Holder: _____ **ID#**:_____ **Group #**:_____

Secondary Insurance: _____**Employer**:_____

Policy Holder: _____ **ID#**:_____ **Group #**:_____

PLEASE ENTER THE BELOW INFORMATION FOR THE PERSON RESPONSIBLE FOR THE BILL***, IF OTHER THAN THE PATIENT***:

Name: _____ Date of Birth: _____ Relationship: _____

Address:_____ Home Phone:_____ Cell: _____

1) BST may disclose my health information for public health activities such as cancer/tumor registry.
2) I understand that I have a right to request and receive a Notice of Practices from BST.

****This Agreement/Consent Will Remain in Effect Unless Revoked by Me in Writing****

_____ _____ _____ _____
Patient Signature Date Spouse or Responsible Party Signature Date