



SME, Inc. USA  
5949 Carolina Beach Road  
Wilmington, NC 28412  
Phone: (800)538-4675  
Fax: (800)560-5424

SME Clinic  
2301 Rexwoods Drive  
Suite 106  
Raleigh, NC 27607  
Phone: (919)977-9566  
Fax: (919)977-9567

Date: \_\_\_\_\_

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

Patient Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ (+4) \_\_\_\_\_

Patient Billing Address (if different from above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ (+4) \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Mobile: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Parent or Responsible Party (if patient is a child): \_\_\_\_\_

Address of Responsible Party (if different from above): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ (+4) \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Mobile: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Referring Physician/Clinic: \_\_\_\_\_

Primary Care Physician/Clinic: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Supplemental (Tertiary) Insurance: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize any holder of medical information about me to release to SME, Inc. USA, Centers for Medicare and Medicaid Services or other health insurances and/or their agents any information needed to determine these benefits and for processing this claim. I agree to be held personally and fully responsible for any amounts not paid by my insurer.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_