

SUMMIT MEDICAL GROUP PATIENT REGISTRATION FORM

ACCOUNT #		DATE		PHYSICIANS NAME			
PATIENT'S FIRST NAME			MI	LAST		BIRTHDATE	AGE
ADDRESS				CITY		STATE	ZIP CODE
SOCIAL SECURITY #	HOME PHONE #	MOBILE PHONE #		WORK OR BUSINESS PHONE #		MARITAL STATUS	SEX
PATIENT'S EMPLOYER'S NAME				EMPLOYER'S ADDRESS			
PHARMACY OF CHOICE					PHARMACY PHONE #		
PHARMACY ADDRESS				CITY		STATE	ZIP CODE
EMAIL ADDRESS (OPTIONAL)							
HAVE YOU BEEN TREATED BY A SUMMIT MEDICAL GROUP PHYSICIAN PREVIOUSLY ? <input type="checkbox"/> YES <input type="checkbox"/> NO				DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTHCARE ? <input type="checkbox"/> YES <input type="checkbox"/> NO			
				DO YOU HAVE A LIVING WILL ? <input type="checkbox"/> YES <input type="checkbox"/> NO			
If yes, Please provide a copy of the above document(s) to the office for your medical record.							

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES (IF DIFFERENT FROM PATIENT)							
FIRST NAME			MI	LAST			
ADDRESS				CITY		STATE	ZIP CODE
SOCIAL SECURITY #	HOME PHONE #	MOBILE PHONE #		WORK OR BUSINESS PHONE #		BIRTHDATE / SEX	
EMPLOYER'S NAME				EMPLOYER'S ADDRESS			

EMERGENCY CONTACT (NOT WITHIN THE SAME HOUSEHOLD)			
NAME	HOME PHONE	WORK OR BUSINESS PHONE	RELATIONSHIP TO PATIENT

INSURANCE INFORMATION			
PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURANCE NAME	EFFECTIVE DATE	INSURANCE NAME	EFFECTIVE DATE
CLAIMS ADDRESS		CLAIMS ADDRESS	
SUBSCRIBER ID NUMBER	GROUP NUMBER	SUBSCRIBER ID NUMBER	GROUP NUMBER
SUBSCRIBER NAME AND ADDRESS		SUBSCRIBER NAME AND ADDRESS	
SUBSCRIBER BIRTHDATE		SUBSCRIBER BIRTHDATE	
SUBSCRIBER SS#	RELATION TO PATIENT	SUBSCRIBER SS#	RELATION TO PATIENT
EMPLOYER NAME, ADDRESS AND PHONE NUMBER		EMPLOYER NAME, ADDRESS AND PHONE NUMBER	
FOR PRESCRIPTIONS, DO YOU USE YOUR <input type="checkbox"/> PRIMARY INSURANCE <input type="checkbox"/> SECONDARY INSURANCE <input type="checkbox"/> OTHER _____			

The Patient or Guarantor is responsible for payment in full of all services rendered by the physicians or employees of Summit Medical Group, PLLC. Payment in full is expected at the time of service unless arrangements are made in advance.

AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

I hereby authorize Summit Medical Group, PLLC to release to the above insurance companies &/or carriers any medical or other information needed for claims reimbursement. I hereby assign, transfer, and set over to Summit Medical Group, PLLC all of my rights, title, and interest to medical reimbursement benefits under my insurance policy with the above documented insurance companies. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me by Summit Medical Group, PLLC.

_____ DATE

_____ SIGNATURE OF PATIENT/GUARDIAN