SUMMIT MEDICAL GROUP PATIENT REGISTRATION FORM

ACCOUNT #	DATE	PHYSICIANS NAME

PATIENT'S FIRST NAME	MIDDLE NAME	LAST	BIRTHDATE	AGE

ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY #	HOME PHONE #	MOBILE PHONE #	WORK OR BUSINESS PHONE #	MARITAL STATUS	SEX

EMPLOYER'S NAME AND ADDRESS	RACE		
		❑ 01 AFRICAN AMERICAN	❑ 08 NATIVE AMERICAN
		❑ 02 ASIAN	❑ 11 OTHER _____
		❑ 03 CAUCASIAN	
		❑ 06 HISPANIC	_____

EMAIL ADDRESS (OPTIONAL)

PHARMACY OF CHOICE	PHARMACY PHONE #

HOW WERE YOU REFERRED TO SUMMIT MEDICAL GROUP ?

HAVE YOU BEEN TREATED BY A SUMMIT MEDICAL GROUP PHYSICIAN PREVIOUSLY ? ☐ YES ☐ NO	DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTHCARE ? ☐ YES ☐ NO DO YOU HAVE A LIVING WILL ? ☐ YES ☐ NO **If yes, Please provide a copy of the above document(s) to the office for your medical record.**

PERSON/GUARANTOR RESPONSIBLE FOR PAYMENT OF SERVICES (IF DIFFERENT FROM PATIENT)

FIRST NAME	MIDDLE NAME	LAST	RELATIONSHIP TO PATIENT

ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY #	HOME PHONE #	MOBILE PHONE #	WORK OR BUSINESS PHONE #	BIRTHDATE	SEX

EMPLOYER'S NAME AND ADDRESS

EMERGENCY CONTACT (NOT WITHIN THE SAME HOUSEHOLD)

NAME	EMERGENCY PHONE NUMBER	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 ☐ PRIMARY INSURANCE ☐ SECONDARY INSURANCE ☐ 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*