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
- ❑ 02 ASIAN
- ❑ 03 CAUCASIAN
- ❑ 06 HISPANIC
- ❑ 08 NATIVE AMERICAN
- ❑ 11 OTHER ______________

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

INSURANCE NAME	EFFECTIVE DATE

CLAIMS ADDRESS

SUBSCRIBER ID NUMBER	GROUP NUMBER

SUBSCRIBER NAME AND ADDRESS

SUBSCRIBER BIRTHDATE

SUBSCRIBER SS#	RELATION TO PATIENT

EMPLOYER NAME, ADDRESS AND PHONE NUMBER

SECONDARY INSURANCE

INSURANCE NAME	EFFECTIVE DATE

CLAIMS ADDRESS

SUBSCRIBER ID NUMBER	GROUP NUMBER

SUBSCRIBER NAME AND ADDRESS

SUBSCRIBER BIRTHDATE

SUBSCRIBER SS#	RELATION TO PATIENT

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*