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	PRIMARY LANGUAGE:

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*

PATIENT CONSENT FOR MEDICAL TREATMENT

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Summit Medical Group, through its individual physicians, employees, and/or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician and provided by Summit Medical Group.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the physician or Summit Medical Group.

I acknowledge that I have received a copy of Summit Medical Group's Notice of Privacy Practices and I understand that the notice is also posted at each location where services are provided and on the internet at www.summitmedical.com. I consent to be called on my cell phone concerning healthcare services rendered to me.

To protect against the transmission of blood-borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood for certain diseases while I am a patient of Summit Medical Group. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood, will be tested. I further understand that my blood will not be tested for these diseases unless ordered by my physician and that the results of all tests will be kept confidential.

I have read this form, or had it read to me, and I certify that I fully understand and accept its contents unless noted.

_____ _____

Patient's Signature Patient's Name (Printed)

_____ _____

Witness Date

Patient, _____, is a minor, or is unable to sign above because: _____.
(Name Printed)

_____ _____

Person Giving Consent Relation to Patient

_____ _____

Witness Date