



**PATIENT INFORMATION FORM**

Patient Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient Sex: M/F Birthdate: \_\_\_/\_\_\_/\_\_\_ Marital Status: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Phone #: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone #: (\_\_\_\_\_) \_\_\_\_\_ Preferred Number: H/C

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

Referring Physician Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Family Physician Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name (if applicable): \_\_\_\_\_ Spouse's Birthday \_\_\_/\_\_\_/\_\_\_

Spouse's SS#: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Relative/Friend (other than spouse) Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

**PRIMARY INSURANCE**

Insurance Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Address: \_\_\_\_\_ Group #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Policyholder DOB: \_\_\_\_\_

**SECONDARY INSURANCE**

Insurance Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Address: \_\_\_\_\_ Group #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Policyholder DOB: \_\_\_\_\_

I hereby permit Summa Physicians, Inc. to release any information acquired in the course of my examination and treatment required to process this claim. I also authorize treatment by the physicians, staff and radiology personnel of Summa Physicians, Inc. I hereby agree to pay any Copays, Deductibles, and amounts over UCR, and/or excluded charges, exceeding payments from insurances with whom Summa Physicians, Inc. does not except assignment with, and/or all Copays and Deductibles with those they do. I hereby request my insurance carrier to pay on my behalf insurance benefits to Summa Physicians, Inc. for services rendered. I understand this authorization will be effective until revoked in writing. Summa Physicians, Inc.'s fees are not established by insurance companies. I am responsible for my account.

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