



PATIENT DEMOGRAPHIC FORM

(This Form is to be updated yearly or with any information changes)

PATIENT INFORMATION

Patient Name: _____ Social Security No.: ____/____/____
Date of Birth: ____/____/____ Age: ____ Sex: M F Marital Status: Single Married Widow/er Divorced Partner
Language Preference if not English: _____ Other communication issues? Yes No What _____
Mailing Address: _____
Street Apt. No. City State Zip
Physical Address (if not same as mailing): _____
Street City State Zip
Drivers License No.: _____ Number State E-Mail Address: _____
Employer: _____ Occupation: _____
Address: _____ Work Phone: (____) _____ - _____
Home Phone: (____) _____ - _____ Cell/Pager No.: (____) _____ - _____
Spouse Name: _____ Date of Birth: ____/____/____ Social Security No.: ____/____/____
Address: _____ Work Phone: (____) _____ - _____
Emergency Contact Name: _____ Emergency Contact Phone: (____) _____ - _____
Address: _____ Relationship: _____

GUARANTOR/PARENT INFORMATION

Responsible Party Name: _____ Date of Birth: ____/____/____ Social Security No.: ____/____/____
Address: _____ Home Phone: (____) _____ - _____
Employer: _____ Work Phone: (____) _____ - _____
Relationship to Patient: _____ Cell/Pager No.: (____) _____ - _____

PATIENT'S INSURANCE INFORMATION ** Please provide Insurance Card and Photo ID to Receptionist**

Primary Insurance Company's Name: _____
Insurance Address: _____
Street Suite No. City State Zip
Name of Policy Holder: _____ Date of Birth: ____/____/____ Social Security No.: ____/____/____
Insurance ID No.: _____ Insurance Group No.: _____
Secondary Insurance Company's Name: _____
Insurance Address: _____
Street Suite No. City State Zip
Name of Policy Holder: _____ Date of Birth: ____/____/____ Social Security No.: ____/____/____
Insurance ID No.: _____ Insurance Group No.: _____

PATIENT'S REFERRAL INFORMATION

Referred By (circle or fill in): Family Friend Hospital Radio Health Care Provider Name: _____
Primary Care Provider: _____ Referring Provider: _____

(Please Read and Sign)

I hereby authorize my insurance benefits to be paid directly to Summit Family Practice, LLC. and I realize I am responsible for paying for non-covered services I understand and I am responsible for all charges incurred on my behalf, including any added costs incurred due any effort to collect for services rendered. I hereby authorize the release of pertinent medical information to insurance carriers.

Responsible Party: _____ Date: _____