SUMMA HEALTH CARE

New Patient Registration Form

Demographic Information

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.

Patient Name: _____ D.O.B: _____/_____/_____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Social Security Number: _____ Sex: _____ Marital Status: _____

E-Mail: _____**@**_____**.** _____

Primary Care Physician: _____Phone Number: _____

Emergency Contact: _____ Phone Number: _____Relationship_____

Employer: _____

Employer Address: _____

Responsible Party Information: ☐Self ☐ Spouse ☐Parent ☐ Other

Responsible Party Address: _____

Responsible Party Home Phone _____ Mobile: _____ Work: _____

Insurance Information:

Primary Insurance Company: _____ Policy ID #: _____ Group #: _____

Name of Policy Holder: _____ Policy holder D.O.B: ____/_____/_____

Secondary Insurance: _____Policy ID#: _____ Group #:_____

Name of Policy Holder: _____ Policy holder D.O.B: ____/_____/_____

***Please have your insurance cards and identification card ready for the receptionist to copy ***

Who can we thank for referring you to us? _____

I have verified the above information I have given is true.

Signature: _____ Date: _____