

**SUMMIT SPORTS MEDICINE**

**PATIENT INFORMATION AND HISTORY FORM**

Chart# \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI. \_\_\_\_\_ SSN \_\_\_\_\_

Sex: Male or Female      Date of Birth \_\_\_\_ - \_\_\_\_ - \_\_\_\_      Age \_\_\_\_\_      Marital Status: S W D M

Home Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

IS ADDRESS: PERMANENT OR TEMPORARY? (circle one)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Patient's Employer/Address (if student, name of school) \_\_\_\_\_

**EMERGENCY CONTACTS**

Relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_

Friend not living with you \_\_\_\_\_ Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Who May We Thank for Referring You to Us? \_\_\_\_\_ Phone \_\_\_\_\_

**SPOUSE OR GUARDIAN**

(Without this information, we cannot file a claim and you will be responsible for the bill the day of service.)

Name of spouse or guardian \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_      SSN \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

**Primary Insurance Information**

Name of Insurance \_\_\_\_\_

Card holder social security# \_\_\_\_\_

Card holder Name \_\_\_\_\_

Date of birth of Card holder \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_

**Secondary Insurance Information**

Name of Insurance \_\_\_\_\_

Card holder social security# \_\_\_\_\_

Card holder Name \_\_\_\_\_

Date of birth of card holder \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_

**I agree the above information is correct.**

\_\_\_\_\_   
 Print Name

\_\_\_\_\_   
 Signature

\_\_\_\_\_   
 Date