

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 _____

Home Phone _____ Work Phone _____

E-mail Address _____ Cell Phone _____

Patient's Employer/ (if student, name of school) _____

Employer Address _____ Phone _____

Nearest Relative (Not living with you) _____ How related _____

Phone _____

Emergency contact (Friend not living with you) _____ Phone _____

Family Physician _____ Phone _____

Who May We Thank for Referring You to Us? _____ Phone _____

*****WITHOUT THE FOLLOWING INFORMATION, WE CAN NOT FILE A CLAIM**

AND YOU WILL BE RESPONSIBLE FOR THE BILL ON THE DAY OF SERVICE***

Primary Insurance Information

Secondary Insurance Information

Name of Insurance _____

Name of Insurance _____

Card holder social security# _____

Card holder social security# _____

Card holder Name _____

Card holder Name _____

Date of birth of Card holder ____/____/____

Date of birth of card holder ____/____/____

Policy Number _____

Policy Number _____

Group Number _____

Group Number _____

Employer _____

Employer _____

Spouse or Legal Guardian Information:

Name of guardian _____ Date of Birth ____/____/____

SSN _____ Home phone: _____

Home Address: _____

Employer Name: _____ Employer phone# _____

Employer Address: _____

Date: _____ Dr: _____



COOPERATIVE
HEALTHCARE
SERVICES, INC.

Chart# _____

Summit Sports Medicine

Disclosure of Protected Health Information

By Law, medical information is confidential unless written authorization is given.

Therefore, I _____, authorize Summit Sports Medicine Associates to release medical information to the following persons:

Name

_____	_____
_____	_____
_____	_____

OR

I request that you DO NOT disclose medical information to anyone other than me. _____

Initials

I can be contacted at:

Day Time Phone # _____

Home Phone # _____

Cell # _____

Leave Message and or Results on Answering Machine

This authorization remains in effect until I give written notification to discontinue.

Patient Signature: _____ Date: ____ / ____ / ____