File Info:

Summit O & P
Patient Information Sheet

Patient Information/ Physician information

Name (first, middle, last)			
Street Address			
City, State, Zip			
Patient Email			
Phone #		Driver's license #	
Cell #		Employer Name	
Date of Birth		Employer Phone #	
Male or Female	M or F	Emergency Contact Name	
Social Security #		Emergency contact phone #	
Referring Doctor		Primary Doctor (req. for Diabetic Items)	

Insurance Information

	Primary Insurance	Secondary Insurance
Ins company Name		
Identification #		
Group #		
Name, DOB of Subscriber and relation to patient		

Accident information (Worker's Compensation or Auto)

Insurance Company	
Claim #	
Date of Injury or Accident	
Claim Adjuster Name and Phone #	
Employer at Time of Accident	

DIAGNOSIS / NATURE OF INJURY: _____

ARE YOU DIABETIC? YES or NO

Assignment of Benefits/ Authority for release of information

I authorize Summit O & P to bill my insurance for payment of services rendered. I authorize Summit O & P to request chart notes, etc from my Doctor's Office regarding services rendered to use with billing my insurance company or receiving prior authorization. I agree to give Summit O & P all my correct insurance billing information or I may be responsible for payment. I understand I am ultimately responsible for the balance of my account and agree to pay in a timely manner.

Patient Signature_____ Date_____

Representative _____ Relationship_____