SUMMIT PEDIATRICS

Patient Information:

Patient Name:_____ _____
Last, First Middle Nickname

Date of Birth: _____ Sex: M/F Phone:_____

Address: _____
Street City State Zip

Please list all other siblings (name and date of birth) 1)_____M/F ____/____/____
2)_____M/F ____/____/____ 3)_____M/F ____/____/____
4)_____M/F ____/____/____ 5)_____M/F ____/____/____

Parent/Guardian Information:

	Guarantor	**Spouse**
Name(s)	_____,	_____
Employer(s)	_____,	_____
Social Security #(s)	_____,	_____
Date of Birth	_____,	_____
Work Phone#(s)	_____,	_____
Cell Phone #(s)	_____,	_____
E-mail Address	_____,	

Name of Parent not living with child (if applicable)_____

Address:_____

Phone:_____ Work/Cell Phone_____

In Case of Emergency (*someone not living in same household*):

Name:_____ Phone:_____

Insurance Information:

Primary Ins.:_____ Group#:_____

Insured's Name:_____ Insured's Birthdate ____/____/____

Subscriber ID#_____ Copay:_____

Secondary Ins:_____ Group#:_____

Insured's Name:_____ Insured's Birthdate ____/____/____

Subscriber ID#_____ Copay:_____

You are responsible for <u>payment of services at the time they are rendered</u>. If we are a "Plan provider and can bill your insurance company, we will do so, but <u>co-payment is always due at the time of service.</u>

<u>Parent/Guardian signature:</u>_____ <u>Date:</u>_____