

SMG

Sumner Medical Group, PLLC

Date: _____

**NEW PATIENT
REQUEST FORM**

Name: _____ DOB: _____

Phone Number: _____

Insurance Company: _____

Who is PCP: _____

Requesting to be seen by Dr. _____

Any immediate family members currently being seen by an SMG Physician?

Comments: _____

Accepted: _____ M.D.: _____

Denied: _____ M.D.: _____

PATIENT INFORMATION SHEET

Thank you for choosing our office! In order to serve you properly, please provide us with the following information. Please PRINT and complete all items requested.

TODAY'S DATE: _____

Who referred you to Sumner Medical Group? _____

Patient's Name: _____

Last

First

Middle

What name do you prefer to be called? _____

Street Address: _____

City: _____ State: _____ Zip: _____ Sex: M or F

Employer _____

Home Phone: _____ Date of Birth: _____ / _____ / _____

Work Phone: _____ Social Security # _____

Marital Status: M S D W (please circle)

Spouse (or Parent, if patient is a minor): _____

Spouse's Social Security #: _____

Address (if different from patient's): _____

City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Group # _____

Insured's Name: _____ Insured's ID # _____

(Name of person who **owns** policy)

Insured's Date of Birth: _____ / _____ / _____ Insured's Employer: _____

Insured's relationship to patient: SELF SPOUSE PARENT OTHER (SPECIFY)

Secondary Insurance: _____ Group #: _____

Insured's Name: _____ Insured's ID # _____

(Name of person who **owns** policy)

Insured's Date of Birth: _____ / _____ / _____ Insured's Employer: _____

Insured's relationship to patient: SELF SPOUSE PARENT OTHER (SPECIFY)

Who should we contact in case of an **EMERGENCY**? _____

That persons relationship to patient: _____

Phone numbers: _____

Does patient have a **LIVING WILL**? YES NO

Does patient have **DURABLE POWER OF ATTORNEY**? YES NO

FINANCIAL INFORMATION

Who is responsible for this patient **financially**? _____

Our billing policy is to collect all copay amounts on the day of service. If you have no insurance, full payment is expected at the time of service. We accept payment by cash, check, Visa, Mastercard or Discover Card. If there is a problem with your insurance company or your billing, please feel free to talk to us about the problem. Please **DO NOT** ignore your billing, as doing so may cause your account to be handled through outside collections efforts.

I, _____ (print your name), understand that I am fully responsible for all charges, whether or not they are covered by insurance. If my insurance does not pay within 30 days, I understand I am responsible for payment. In the event I do not pay as outlined above and collection efforts are necessary, I agree to pay all costs of collection including attorney fees. I further authorize the release of any medical information or records to my insurance company or their fiscal intermediary, as necessary incident to obtaining payment, and I hereby assign their payment for medical services rendered.

Signature of Patient / Parent / Guardian

Date

METHOD OF PAYMENT

How will you be paying your share of the billing today?

Please check one:

Check _____ Cash _____ Mastercard _____ VISA _____ Discover Card _____

Please Note: A service fee of \$20.00 will be charged for any returned check.

APPOINTMENT CANCELLATION

A **minimum** of twenty-four (24) hours notice must be given to cancel or reschedule an appointment.