

SUMNER MEDICAL GROUP, PLLC

Patient Demographics Form

Today's Date _____ Referred by: _____

Patient Name:		Email:	
Mailing Address:			
Home Phone:		Work Phone:	
Cell Phone:		Birth Date:	
May we leave message on your phone? Yes No		Sex:	
Social Security Number:		Marital Status:	
Race:		Ethnicity: Hispanic Not Hispanic	
Language:		Can we call you at work if we need to? Yes No	
Patient's Employer:		Phone Number:	
Emergency Contact Name:		Responsible Party Date of Birth:	
Responsible Party:		Responsible Party Social Security Number:	
Responsible Party Address:		Phone Number:	
Primary Insurance:		Prim. Insurance Address:	
Subscriber Name:		Date Of Birth:	
Subscriber ID:		Group Number:	
Secondary Insurance:		Phone Number:	
Sec. Insurance Address:		Subscriber Name:	
Subscriber Name:		Date Of Birth:	
Subscriber ID:		Group Number:	
Pharmacy Name:		Pharmacy Number:	
Pharmacy Address:			
Do you have a Living Will? <input type="radio"/> Yes <input type="radio"/> No		Do you have Power of Attorney? <input type="radio"/> Yes <input type="radio"/> No	

- **Assignment and Release**
 I, the undersigned, certify that I or my dependent have insurance with the previously stated insurance carrier and assign to **Sumner Medical Group, PLLC**. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize **Sumner Medical Group, PLLC**. to release all information necessary to secure payment of benefits. I further authorize the use of this signature on all insurance submissions. I also consent to treatment for my condition as directed by my physician. There will be a \$25.00 charge for all returned checks.
- **Consent for Prescription History**
 I consent to allow **Sumner Medical Group, PLLC** to access my prescription history when integral to my care or deemed medically necessary.
- **Protected Health Information** *I have received the brochure on Privacy Practices. I grant permission for **Sumner Medical Group, PLLC** to discuss my personal information regarding my care, treatment or financial obligations to the people I have designated below. Authorization will remain in effect until revoked in writing.*

Name	Relationship
Name	Relationship

I have reviewed all of the statements above to include **Assignment and Release, Consent for Prescription History** and the **Protected Health Information** and agree to all policies.

 Signature of Patient/Legal Guardian

 Date