# Sumner Medical Group, PLLC Patient Demographics Form

**Today's Date:**_____ _____**Primary Care Doctor**:_____**Referred By:**_____

**Patient's Full Name**:_____

**Email:**_____Would you like to receive correspondence via e-mail? **YES** **NO**

**Address**:_____ **City**:_____**State**:_____ **Zip Code**_____

**Home Phone**:_____**Cell Phone**:_____**Work Phone**:_____

May we leave a message on your phone? **YES** **NO** **Date of Birth**:_____

**Gender:** Male Female **Social Security Number**:_____

**Marital Status:** Married Single Divorced Separated Widowed **Ethnicity:** Not Hispanic Hispanic

**Race:** Asian Black Hispanic White **Language:** English Spanish Other

**Patient's Employer**:_____ Can we contact you at work? **YES** **NO**

**Emergency Contact Name**: _____**Relationship**_____ **Phone Number**_____

**Responsible Party:**_____**Responsible Party Soc Sec#**_____

**Responsible Party Date of Birth:**_____ **Responsible Party Address:**_____

**Pharmacy Name**:_____**Pharmacy Number**:_____

**Pharmacy Address**:_____

Do you have a Living Will? **YES** **NO** Do you have a Power of Attorney? **YES** **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 service 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:_____

Name:_____Relationship:_____

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

Signature of Patient/ Legal Guardian:_____Date:_____