SUMMIT ORTHOPEDIC SURGERY
PATIENT'S INFORMATION

TODAY'S DATE: _______________

PATIENT'S NAME: ____
FIRST MIDDLE LAST

ADDRESS: ____
STREET APT# CITY ZIPCODE

PHONE: ________________________CELL: _________________________ WORK: __________________________

DATE OF BIRTH: _________________ AGE: __________ EMAIL: ____

SOCIAL SECURITY NUMBER____________________ GENDER: _____ MARITAL STATUS: ___________________

ANSWERS ARE CONFIDENTIAL AND USED SOLELY FOR ELECTRONIC HEALTH RECORDS DATA FOR MEANINGFUL USE AND HAVE NO BEARING ON TREATMENT PROVIDED.

PREFERRED LANGUAGE:

- ☐ English
- ☐ Spanish

RACE:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other: __________________________

ETHNICITY (**If no response is given, your choice will be automatically selected as "Decline to Answer"**):

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Decline to Answer
- ☐ Unknown

FAMILY DOCTOR: ____________________________ REFERRED BY: _____________________________________

EMPLOYER NAME AND ADDRESS: ____

OCCUPATION: ___________________ REFERRED FOR VISIT: ____

DATE OF ONSET: __________ EMERGENCY CONTACT & NUMBER: _____________________________________

NAME OF PHARMACY: ____________________ PHARMACY PHONE NUMBER: ___________________________

ADDRESS: ____
STREET APT# CITY ZIPCODE

INSURANCE/CLAIM INFORMATION

PRIMARY INSURANCE COMPANY: ____
NAME ADDRESS

PHONE: ___________________ ID#: __________________________________ GROUP #: ____________________

POLICY HOLDER: ____ DATE OF BIRTH: _________________

SECONDARY INSURANCE COMPANY: ____
NAME ADDRESS

PHONE: ___________________ ID#: __________________________________ GROUP #: ____________________

POLICY HOLDER: ____ DATE OF BIRTH: _________________

DID INJURY OCCUR ON THE JOB? YES__________ NO___________ DATE OF INJURY: ______________________

IS INJURY RELATED TO AUTO ACCIDENT? YES_________ NO_________ DATE OF INJURY: ________________

ATTORNEY'S NAME: ____ PHONE: _________________________

ADDRESS: ____

DATE: ______________ **SUBSCRIBER/PATIENT'S SIGNATURE:** ____