

# Patient Information



Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Gender: M/F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Address: \_\_\_\_\_ Apt. \_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Status: Single/Married/Other: \_\_\_\_\_ Employed/Student/Other: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Address \_\_\_\_\_

Referring Physician Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Primary health insurance:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

Group #: \_\_\_\_\_ ID#: \_\_\_\_\_ Referral Required: Yes/No

Insurance address: \_\_\_\_\_

Insured party: \_\_\_\_ Self \_\_\_\_ Other: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Relationship to policyholder: \_\_\_\_\_

Policyholder Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M/F

Policyholder Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_

Policyholder Occupation: \_\_\_\_\_

**Secondary health insurance:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

Group #: \_\_\_\_\_ ID#: \_\_\_\_\_ Referral Required: Yes/No

Insurance address: \_\_\_\_\_

Insured party: \_\_\_\_ Self \_\_\_\_ Other: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Relationship to policyholder: \_\_\_\_\_

Policyholder Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M/F

Policyholder Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_

*I certify that the information I have provided is accurate. I authorize release of medical or other information necessary to process this claim. I understand that I am responsible for any unpaid balances. I also understand that it is my responsibility to obtain the necessary referrals, if appropriate, and copy of my current medical insurance cards prior to being treated by Summit Breast Care, L.L.C., and understand that if I do not provide the necessary referrals and copy of insurance cards, I will accept 100% of financial responsibility.*

Patient or Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_