Summit Digestive and Liver Disease Specialists

Patient Information

Name_____ Social Security # _____

Address_____

City/State/Zip _____

Home Phone # _____ Business Phone # _____

Cell Phone# _____ Email _____

Sex: Male Female Birthdate _____ Single Married Widowed Divorced Separated

Patient Employed by _____ Occupation _____

Business Address _____

City/State/Zip _____

Emergency Contact _____ Phone # _____

Whom may we thank for referring you to our clinic? _____

Primary Insurance

Insured's name _____Social Security # _____

Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____

Employer_____ Business Phone # _____

Insurance company _____

Identification # _____ Group # _____

Secondary Insurance

Insured's name _____Social Security # _____

Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____

Employer_____ Business Phone # _____

Insurance company _____

Identification # _____ Group # _____

Assignment of Benefits and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage with the above named company or companies and assign all insurance benefits, if any, directly to Summit Digestive and Liver Disease Specialists for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Summit Digestive and Liver Disease Specialists to release any and all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Patient or Responsible Party Signature Date