STEPHEN J. SOMMER, MD SUZANNE M. SOMMER, NP

FAMILY PRACTICE TRAVEL IMMUNIZATIONS WOMENS' HEALTH WORKERS' COMPENSATIO

WELCOME TO OUR OFFICE

PATIENT'S ACCOUNT#	GUARANTOR		CATEGORY
PATIENT'S NAME LAST	FIRST	MIDDLE	HOME PHONE
HOME ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY#	DATE OF BIRTH	PLACE OF BIRTH	SEX MALE FEMALE
EMPLOYER	WORK ADDRESS		WORK PHONE
PATIENT'S OCCUPATION	EMERGENCY CONTACT NAME		PHONE
PRIMARY CARE PROVIDER IF NOT DR. SOMMER	ADDRESS		PHONE

PRIMARY INSURANCE SHOW CARD TO RECEPTIONIST	INSURED'S NAME		RELATION TO PATIENT
INSURANCE COMPANY NAME	ADDRESS		PHONE
SUBSCRIBER NO.	GROUP NO.	EFFECTIVE DATE	CO-PAYMENT AMOUNT
SECONDARY INSURANCE SHOW CARD TO RECEPTIONIST	INSURED'S NAME		RELATION TO PATIENT
INSURANCE COMPANY NAME	ADDRESS		PHONE
SUBSCRIBER NO.	GROUP NO.	EFFECTIVE DATE	CO-PAYMENT AMOUNT

HOW DID YOU HEAR ABOUT OUR OFFICE?	INSURANCE BOOK PHONE BOOX	HILL PHYSICIANS REFERRED BY	SUMMITT MEDICAL CENTER	MEDICAL SOCIETY
NAMES OF OTHER FAMILY MEMBERS SEEN IN THIS OFFICE				
MARITAL STATUS S M W D OTHER	NAME OF SPOUSE OR PARTNER	WORK PHONE		
SPOUSE/ PARTNER EMPLOYER			WORK PHONE	

IF PATIENT IS A MINOR OR STUDENT:		
MOTHER'S NAME	HOME ADDRESS	HOME PHONE
EMPLOYER	WORK ADDRESS	WORK PHONE
FATHER'S NAME	HOME ADDRESS	HOME PHONE
EMPLOYER	WORK ADDRESS	WORK PHONE

PLEASE NOTE: If there is any question regarding the bill, the person who is registering today will be responsible for payment. If patient is a minor, the person registering for the patient will be responsible. If you are not insured we would appreciate payment at the time of the visit, however if necessary a payment plan can be arranged.

RELEASE STATEMENT FOR (print patient's name): ______________________________

1. I authorize Dr. Sommer to perform diagnostic tests and provide treatment necessary for medical evaluation and health care for the patient named above.
2. I accept responsibility for all charges incurred in the medical evaluation and health care of the patient named above.
3. I authorize the payment of medical benefits be made directly by my insurer to Dr. Sommer for services rendered.
4. I give Dr. Sommer and his staff permission to provide relevant medical information about the patient named above to my insurer as necessary to process my insurance claim.
5. I give Dr. Sommer and his staff permission to provide relevant medical information about the patient named above to other medical providers and facilities to which he refers me.

SIGNED: ______________________________ **RELATION TO PATIENT:** ______________ **DATE:** __________