FOR OFFICE USE ONLY

CHART # ______________________

DR. ______________________

☐ **NEW PATIENT** ☐ **UPDATE**

MARK S. SUMIDA, M.D.

PATIENT INFORMATION

Name ______________________

Address ______________________

City ______________ State ____ Zip ______

SS# ______________ Marital Status: S M W D

Date of Birth ______________ Age ____ Sex: M F

Home Phone ______________________

Work Phone ______________ Ext. ______

Employer ______________________

Address ______________________

City ______________ State ____ Zip ______

RESPONSIBLE PARTY (if other than patient)

Name ______________________

Address ______________________

City ______________ State ____ Zip ______

SS# ______________________

Relationship To Patient ______________________

Home Phone ______________________

Work Phone ______________ Ext. ______

Employer ______________________

Address ______________________

City ______________ State ____ Zip ______

In Case of Emergency, Contact: ______________________ Phone # ______________

INSURANCE INFORMATION

How Will You Be Paying Today? ☐ Cash ☐ Check ☐ Credit Card (M/C, Visa)

Primary Insurance ______________________

Address ______________________

City ______________ State ____ Zip ______

Insured SS# ______________ Date of Birth ______________

Group # ______________ Policy # ______________

Employer ______________________

Secondary Insurance ______________________

Address ______________________

City ______________ State ____ Zip ______

Insured SS# ______________ Date of Birth ______________

Group # ______________ Policy # ______________

Employer ______________________

SYMPTOMS:

Nature of Complaint ______________________

Date of Injury/Onset of Symptoms ______________________

Were You Injured on the Job? ☐ Yes ☐ No

Were You Injured in an Auto Accident? ☐ Yes ☐ No

Referred by (hospital or physician) ______________________

Were X-Rays Made? ☐ Yes ☐ No

I authorize the release of medical or other information about me to the above listed insurance provider(s). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

This office operates solely on a cash basis. Accounts should be paid within 60 (sixty) days to prevent further action. I/we agree to pay any collection or attorney fee owned in addition to court costs if charges are not paid within the terms stated above and legal action is necessary to effect collection.

I/we certify that I/we have read all of the above and the information given is true.

I/we give permission for my/our minor child to receive medical attention.

PATIENT/GUARANTOR
SIGNATURE ______________________ DATE ______________