

Summit Women's Care Group Health Intake Form

Date: _____

Patient First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell Phone: _____

SSN: _____ Date of Birth: _____ Marital Status: _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Phone Number: _____ Employer's Name: _____

Email Address: _____

(For our patient satisfaction surveys! ©)

Group Health Insurance Information (ALL FIELDS ARE REQUIRED)

Primary Insurance Name: _____ Customer Services Phone#. _____

Policy Holder Name: _____ SSN: _____ Date Of Birth: _____

Phone #: _____ Policy Holder Employer: _____

ID Number: _____ Group/Policy #: _____

Secondary Insurance Name: _____ Customer Services Phone#. _____

Policy Holder Name: _____ SSN: _____ Date Of Birth: _____

Phone #: _____ Policy Holder Employer: _____

ID Number: _____ Group/Policy #: _____

Referring Physician Information:

Referring Physician -First Name: _____ Last Name: _____

Phone Number: _____

- We bill your insurance company as a courtesy to you. It is your responsibility to know your benefits, and you are ultimately responsible for payment if a service is not covered. Please be prepared to make a payment or co-payment at the time of service. Thank you

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