

Patient Registration

OB GYN
 Sydni Crowell, MD
 Suzanne Rashidian, DO, FACOG

INTERNAL MEDICINE
 Ramin Rashidian, DO, FACOI

NURSE PRACTITIONERS
 Emily Clark, APRN
 Jennifer Meunier, APRN

AESTHETICS
 Brooke Waninger-White, MA, CLT

PATIENT NAME: First _____ Last: _____		DOB _____	AGE _____	CELL PHONE _____
HOME ADDRESS _____		CITY _____	STATE _____	ZIP CODE _____
OCCUPATION _____	SOCIAL SECURITY NO. _____	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	SEX _____	HOME PHONE _____
EMPLOYER _____	ADDRESS _____			WORK PHONE _____
SPOUSE (OR PARENT) _____	SPOUSE (OR PARENT) EMPLOYER _____			SPOUSE (OR PARENT) WORK PHONE _____
PRIMARY CARE PHYSICIAN _____	ADDRESS _____			TELEPHONE _____
PREFERRED PHARMACY (NAME) _____	ADDRESS _____			TELEPHONE _____

EMAIL ADDRESS _____

BILLING AND INSURANCE INFORMATION

PRIMARY INSURANCE	INSURANCE COMPANY NAME _____		ID OR POLICY NUMBER _____	GROUP/CODE _____
	INSURANCE COMPANY ADDRESS _____		POLICYHOLDER'S SOCIAL SECURITY _____	
	POLICYHOLDER'S NAME _____	SEX _____	HOME PHONE _____	RELATIONSHIP TO PATIENT _____
	POLICYHOLDER'S ADDRESS _____		WORK PHONE _____	POLICYHOLDER'S DATE OF BIRTH _____
SECONDARY INSURANCE	INSURANCE COMPANY NAME _____		ID OR POLICY NUMBER _____	GROUP/CODE _____
	INSURANCE COMPANY ADDRESS _____			
	POLICYHOLDER'S NAME _____	SEX _____	POLICYHOLDER'S DATE OF BIRTH _____	RELATIONSHIP TO PATIENT _____

HOW DID YOU HEAR ABOUT US?

- PHYSICIAN _____
- PATIENT/FRIEND _____
- HEALTH FAIR _____
- WEBSITE/FACE BOOK _____
- INTERNET _____
- MESSENGER-INQUIRER _____
- OWENSBORO PARENT MAGAZINE _____
- BILLBOARDS _____
- NEWCOMERS AD/POSTCARD _____
- LOCAL DIRECTORY/which? _____
- OTHER: _____

BILLING POLICY AND PATIENT AUTHORIZATION

Payment is required at the time services are rendered and is the responsibility of the patient, parent, or guardian. Unless other arrangements are made, any unpaid balances are due within 30 days of receipt of the invoice. Payment is accepted in the form of cash, check, credit card, or money order.

Cancellation of an appointment with less than 24 hours' notice or any appointment missed without prior notification may be subject to a \$50 cancellation charge. After three missed appointments, the scheduling of future appointments will be at the discretion of the practice.

I, the patient named above, hereby authorize Summit Medical Specialists to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company, as referenced above, be made directly to the above named provider (or in the case of Medicare Part B benefits, to myself or the party who accepts assignment.)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either the above-named carrier or me at any time in writing.

I authorize the provider or designated representative to contact me by telephone about appointments, billing, and medical care.

As the patient or parent or guardian, I agree to the above terms and conditions.

 Date: _____

 Signature of Patient or Guardian: _____