the SUMMIT
Institute for Orthopedics, Spine & Human Movement

Patient Name **DOB**

Patient Name: _____ _____ _____ SS#:_____
(First) (MI) (Last)

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: Single Married Widowed Divorced

Home Address: _____ P.O. Box: _____

City.:_____ State:_____ Zip Code: _____

Home Phone:( ) _____ Cell Phone:( ) _____ E-mail address: _____

Employer: _____ Work Phone: ( ) _____ Spouse Name: _____

Spouse Employer:_____ Work Phone: ( ) _____ Spouse DOB: _____

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

Referring Physician: _____ Primary Physician: _____

Pharmacy & Location: _____ Phone: ( ) _____

I give permission for Summit Surgical, DBA Pinnacle Rehabilitation to contact the patient's pharmacy for a list of medications. Yes No

Race: Hispanic Asian Caucasian Black/African American American Indian or Alaska Native Other: _____

Preferred Language: English Spanish Other: _____

Ethnicity (Nationality-cultural background): Hispanic/Latino Non-Hispanic/Latino Other

-Person Responsible for Payment of Account-

Name: _____ Relationship: _____

Address: _____ Home Phone: ( )_____

City, St., Zip: _____ Other Phone: ( )_____

-Insurance Information-
Please Present Card(s) for Copying

Primary Insurance: _____ Policy #: _____ Group #: _____

Ins. Address: _____ Ins. Phone: _____

Policy Holder Name: _____DOB: _____ SS#: _____

Policy Holder Address: _____ City, St., Zip_____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Ins. Address: _____ Ins. Phone: _____

Policy Holder Name: _____ DOB: _____ SS#: _____

Policy Holder Address: _____ City, St., Zip_____

Other Insurance: _____ Policy #: _____ Group #: _____

Ins. Address: _____ Ins. Phone: _____

Policy Holder Name: _____ DOB: _____ SS#: _____

Policy Holder Address: _____ City, St., Zip_____

-Complete if Student or Under the age of 18-

Father Information **Mother Information**

Name: _____ Name: _____

Home Phone: ( ) _____ Home Phone: ( ) _____

Work Phone: ( ) _____ Work Phone: ( ) _____

SS#: _____ DOB: _____ SS#: _____ DOB: _____

I hereby give my consent to Summit Surgical, DBA Pinnacle Rehabilitation and its business associates to use and disclose my protected health information for the purpose of treatment, payment, and health care operations as noted in the Notice of Privacy Policies provided to me by the practice. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full. If Summit Surgical, DBA Pinnacle Rehabilitation chooses to accept assignment of my health insurance benefits, I hereby assign all payments to which I am entitled. I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I take full responsibility for all costs incurred by my failure to pay for services rendered.

Signature of Patient or Patient's Representative: _____ Date: _____

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SURGICAL HISTORY

Please list all previous surgeries and the approximate year:

I HAVE NOT HAD ANY SURGERIES

Surgery:	Year:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Surgery:	Year:
Pacemaker	_____
Heart Stents	_____
Bypass Surgery	_____
Replacement Valves	_____
Defibrillator	_____

SOCIAL HISTORY

Hand Dominance: Right Left Ambidextrous

How often do you exercise? Never Occasionally Daily

Type: _____

Do you live alone? Yes No

MEDICATIONS & ALLERGIES

Please list all medications which you are currently taking: (include vitamins, supplements, herbs, **over the counter**, etc.)

Currently taking **NO** medications (including over the counter)

Medication	**Dose**

Do you have any allergies? Yes No If yes, please list below with the **reaction** to the allergy:

_____
_____
_____
_____