Summit Pain Clinic
Demographic Intake Form

Last Name_____ First_____ MI _____

Preferred Name _____ Date of Birth _____ Age_____ Sex _____

SSN _____ Marital Status ___S___M___D___W___Separated

Mailing Address _____
Street/PO Box City State Zip

Physical Address_____
Street/PO Box City State Zip

Home Phone_____Cell Phone_____ Preferred method of contact: Home Cell Work Email

Email Address_____ Preferred Pharmacy_____ Phone_____

Patient Employer_____ Phone_____ Occupation_____ F/T P/T

Emergency Contact_____ Relationship_____ Phone_____

Spouse's Name_____ Spouse's Employer_____ Phone_____

PARENT OR LEGAL GUARDIAN INFORMATION

_____ _____ _____ _____ _____
Mother's Name Mailing Address City State Zip

_____ _____ _____ _____
Mother's Social Security Number Mother's Home # Mother's Employer Mother's Work #

_____ _____ _____ _____ _____
Father's Name Mailing Address City State Zip

_____ _____ _____ _____
Father's Social Security Number Father's Home # Father's Employer Father's Work #

INSURANCE INFORMATION

Primary Insurance Company:_____
Address_____ Phone:_____
Street/PO Box City State Zip

Name of Insured:_____ Social Security Number:_____
Policy Number:_____ Group Number:_____ Effective Date:_____
Policy Holder's Date Of Birth:_____ Relationship to Patient:_____

Secondary Insurance Company:_____
Address_____ Phone:_____
Street/PO Box City State Zip

Name of Insured:_____ Social Security Number:_____
Policy Number:_____ Group Number:_____ Effective Date:_____
Policy Holder's Date Of Birth:_____ Relationship to Patient:_____

Signature (Parent or guardian if a minor) _____ **Date / Time** _____