SUMMIT THERAPY & HEALTH SERVICES

CENTERED ON EXCELLENCE

Minor Patient Information

Today's Date: _____

Name: _____ Date of Birth: _____/_____/_____
(Last) (First) (Middle)

Billing Address: _____
(Street) (City) (State) (Zip)

Sex: ☐ Male ☐ Female

Primary Physician: _____ Referring Physician: _____

Parent/Guardian 1 Name: _____ Phone: _____

Relationship to Patient: _____

Parent/Guardian 2 Name: _____ Phone: _____

Relationship to Patient: _____

Guarantor Name: _____

Social Security: _____ - _____ - _____ DOB: _____

Address: _____

Would you like to be reminded of appointments? ☐ Phone call ☐ Text ☐ Email ☐ No Thanks

Patient Email (for appointment reminders): _____

Insurance: Please provide us with your card so that we can make a copy of it. If you are not the insurance subscriber please fill in:

Subscriber: _____ Subscriber DOB: _____

Subscriber Social Security: _____-_____-_____

Revised: 01-17-19