Frederick T. Sutter, MD, LLC
Center for Wellness Medicine

PATIENT DEMOGRAPHICS

Today's Date: ____________________

Patient Name: ______________________________ DOB: ___________________________

Address: ___________________________________ Sex: FEMALE MALE

_______________________________________ SSN#: ___________________________

Home Tele #: ______________________________ Cell #:___________________________

Work Tele#: ______________________________ Employer Name: ______________________________

Employer Address : ____

E-Mail: ____ Referred By: ______________________________

I authorize Dr. Sutter's office to send promotional and informational emails to my email address.

Emergency Contact: _______________________ Tele#: ________________ Relationship: _______________

Emergency Contact Address: ____

Marital Status:

- ☐ Never Married
- ☐ Married
- ☐ Annulled
- ☐ Polygamous
- ☐ Domestic Partner
- ☐ Widowed
- ☐ Separated
- ☐ Divorced
- ☐ Interlocutory

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient Declined

Race:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native
- ☐ Hawaiian/other Pacific Islander
- ☐ White
- ☐ Patient Declined

PLEASE COMPLETE THE FOLLOWING INSURANCE INFORMATION:

Primary Care Physician: ____

Tele #: ____

Address: ____

PRIMARY INSURANCE: ____

POLICY #:_____________________________ GROUP #:________________________

INSURED NAME: ____

2ND INSURANCE: ____

POLICY #: _____________________________ GROUP #: ________________________

INSURED NAME: ____

If visit is related to a Worker's Comp. or Motor Vehicle Accident injury, please complete the following information:

INSURANCE NAME: ____

DATE OF INJURY OR ACCIDENT: __________________ CLAIM #: _________________________

ADJUSTER NAME: _________________________________ TELE #: _________________________

ATTORNEY'S NAME:________________________________ TELE #: _________________________

Please read and sign back page

*******PLEASE READ AND SIGN THE FOLLOWING*******

AUTHORIZATION TO PAY BENEFITS: I authorize services to be submitted to the above health insurance carrier(s) and payment of insurance or government benefits to be paid directly to Frederick T. Sutter, MD, LLC.

AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any medical or other information necessary to determine benefits and process covered services provided by Frederick T. Sutter, MD, LLC.

FINANCIAL AGREEMENT: I understand that I am responsible for all charges related to any services or supplies not covered by my insurance. Patient copayment will be paid at time of service. Payment of insurance balances are expected within 30 days of receipt of patient billing statement. I understand that some services or products recommended by the office of Frederick T. Sutter, MD, LLC, are not covered by insurance. Payment is expected at the time of service for these supplies or services. I understand that Frederick T. Sutter MD, LLC reserves the right to report delinquent accounts to a collection agency.
A copy of this authorization will be deemed as valid as the original authorization.

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PATIENT OR AUTHORIZED PERSON'S SIGNATURE DATE