

INSURANCE INFORMATION



PRIMARY INSURANCE

INSURANCE COMPANY: _____ CO-PAY: _____
GROUP #: _____ SUBSCRIBER #: _____
INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____
SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PHONE #: _____ EXT: _____
INSURED EMPLOYED BY: _____ BUSINESS ADDRESS: _____
CITY: _____ STATE _____ ZIP: _____ BUSINESS PHONE #: _____
POLICY EFFECTIVE DATE: _____

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? YES NO
INSURANCE COMPANY: _____ CO-PAY: _____
GROUP #: _____ SUBSCRIBER #: _____
INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____
SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PHONE #: _____ EXT: _____
INSURED EMPLOYED BY: _____
BUSINESS ADDRESS: _____ CITY: _____ STATE _____ ZIP: _____
BUSINESS PHONE # : _____
POLICY EFFECTIVE DATE: _____

PARENT/GUARDIAN INFORMATION

NAME: _____ RELATIONSHIP TO PATIENT: _____
DRIVERS LICENSE #: _____ STATE ISSUED: _____

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF VISIT

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date: _____