INSURANCE INFORMATION

Please be prepared to give your insurance card(s) to the receptionist at every visit. This will be scanned into our system to enable us to submit claims to your insurance company on your behalf.

Patient Name:_____ Today's Date:_____

Patient's DOB:_____

****SUBSRIBER INFORMATION:*All information below pertains to the person who carries the insurance*****

Primary Insurance Company:_____ Effective Date:_____

Last Name:_____
First Name:_____
Is this person a patient here? Yes No
Address:_____
_____
City:_____State:_____
Zip Code:_____
Copay amount:_____
Employer/Group Name:_____
Group Number:_____
ID/Contract/Policy #:_____

Primary Phone:(_____)_____-_____
Secondary Phone:(_____)_____-_____
Work Phone:(_____)_____-_____

Gender: Male Female
Birthdate:_____
Social Security Number:_____
Patient's Relationship to insured: Please circle one
Self Spouse Child Other

Secondary Insurance Company:_____ Effective Date:_____

Last Name:_____
First Name:_____
Is this person a patient here? Yes No
Address:_____
_____
City:_____State:_____
Zip Code:_____
Copay amount:_____
Employer/Group Name:_____
Group Number:_____
ID/Contract/Policy #:_____

Primary Phone:(_____)_____-_____
Secondary Phone:(_____)_____-_____
Work Phone:(_____)_____-_____

Gender: Male Female
Birthdate:_____
Social Security Number:_____
Patient's Relationship to insured: Please circle one
Self Spouse Child Other

****For all minor patients, statements will be addressed to the carrier of primary insurance**