

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: _____

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

Primary Insurance Company: _____ Effective Date: _____

Last Name: _____

Primary Phone: (____) _____ - _____

First Name: _____

Secondary Phone: (____) _____ - _____

Is this person a patient here? Yes No

Work Phone: (____) _____ - _____

Address: _____

Gender: Male Female

City: _____ State: _____

Birthdate: _____

Zip Code: _____

Social Security Number: _____

Copay amount: _____

Patient's Relationship to insured: Please circle one

Employer/Group Name: _____

Self Spouse Child Other

Group Number: _____

ID/Contract/Policy #: _____

Secondary Insurance Company: _____ Effective Date: _____

Last Name: _____

Primary Phone: (____) _____ - _____

First Name: _____

Secondary Phone: (____) _____ - _____

Is this person a patient here? Yes No

Work Phone: (____) _____ - _____

Address: _____

Gender: Male Female

City: _____ State: _____

Birthdate: _____

Zip Code: _____

Social Security Number: _____

Copay amount: _____

Patient's Relationship to insured: Please circle one

Employer/Group Name: _____

Self Spouse Child Other

Group Number: _____

ID/Contract/Policy #: _____

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