

INSURANCE INFORMATION

PATIENT NAME _____

For your protection, we will request a photo ID to verify information provided.

PRIMARY INSURANCE

Name of Insured _____ Relationship _____

Birthdate _____ SS# _____

Employer _____ Work Phone No. _____

Will you present your insurance card to us so that we may make a copy? Yes No

If yes, you do not need to complete the following section.

Insurance Co. _____ Phone No. _____

Claims Address _____

City _____ State _____ ZIP _____

Group# _____ Policy# _____ Emp. ID# _____

SECONDARY INSURANCE (Do you have additional insurance coverage? If so, please complete the following.)

Name of Insured _____ Relationship _____

Birthdate _____ SS# _____

Employer _____ Work Phone No. _____

Will you present your insurance card to us so that we may make a copy? Yes No

If yes, you do not need to complete the following section.

Insurance Co. _____ Phone No. _____

Claims Address _____

City _____ State _____ ZIP _____

Group# _____ Policy# _____ Emp. ID# _____

Patient/Guardian Signature _____ Date _____