INSURANCE INFORMATION

Date: _____

Patient Name: _____

Date of Birth: _____

Primary Insurance Company:

Name: _____

Address: _____
(Generally located on back of card)

City: _____ State: _____ Zip: _____

Phone Number: _____

Subscriber #: _____ Group #: _____

Subscriber Name: _____

Relationship: ☐ Self ☐ Spouse / Partner Date of Birth: _____

Effective Date: _____

Secondary Insurance Company:

Name: _____

Address: _____
(Generally located on back of card)

City: _____ State: _____ Zip: _____

Phone Number: _____

Subscriber #: _____ Group #: _____

Subscriber Name: _____

Relationship: ☐ Self ☐ Spouse / Partner Date of Birth: _____

Effective Date: _____

I understand the clinic will verify my insurance coverage but that this does not guarantee payment by the insurance company and I will be responsible for all charges.

_____ _____
Signature of Patient or representative Date