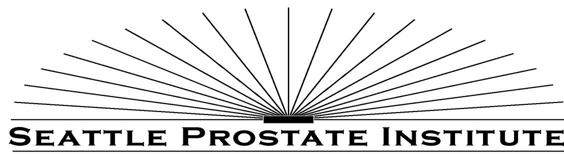

Date:______________________________

INSURANCE INFORMATION:

Patient Name:____

SS#:______________________________ DOB:______________________________

Primary Insurance Company:

Name:____

Address: ____
(Generally located on back of card)

____

Phone Number: ____

Subscriber #: ______________________________Group #: ______________________________

Subscriber Name:____

Relationship: Self Spouse / Partner Birthdate: ______________________________

Effective Date:______________________________

Secondary Insurance Company:

Name:____

Address: ____
(Generally located on back of card)

____

Phone Number: ____

Subscriber #: ______________________________ Group #:______________________________

Name:____

Relationship: Self Spouse / Partner Birthdate: ______________________________

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)