Date: ____________________

Patient's Name: ____

Patient's DOB: ____

INSURANCE INFORMATION (Please present insurance card at time of check in)

PRIMARY Insurance Name ____

Name of Insured __________________ Relationship to patient __________
Insured's ID # __________________ Group # __________
Card Holders SSN if different from card ID # __________________
Card Holders Date of Birth __________________
Employer Name __________________
Card Holders Address if different from patients address __________________

SECONDARY Insurance Name ____

Name of Insured __________________ Relationship to patient __________
Insured's ID # __________________ Group # __________
Card Holders SSN if different from card ID# __________________
Card Holders Date of Birth __________________
Employer Name __________________
Card Holders address if different from patients address: __________________

FOR MINORS
Mothers Name __________________ Date of Birth __________
Address ____
Phone Number __________________ Work/cell __________

Fathers Name __________________ Date of Birth __________
Address ____
Phone Number __________________ Work/cell __________

Responsible party name and billing address if different from patients address:

____

____

I authorize the release of medical information to my primary/referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature __________________ **Date** __________