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 ____

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____

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:

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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 ________________