PATIENT INSURANCE AND BILLING INFORMATION

Patient's Name: _____ DOB:_____ M___ F____
Street Address: _____
City_____ State:_____ Zip: _____ Marital Status: M___S____W____D___ Sep___
(Check one)
Home Tel: ( )_____Work Tel: ( )_____
Cell Phone: ( )_____ How were you referred?:_____
Email address: _____

PRIMARY INSURANCE:
Insurance company:_____
Authorization #:_____
Address: _____
_____
Insurance telephone:_____
Insurance ID#_____ Group#:_____
Subscriber:_____ Subscriber DOB:_____ M__ F____
Subscriber address:_____
_____
Employer: _____
Address: _____
Relationship of patient to subscriber: (Circle one) Self Spouse Child Other

SECONDARY INSURANCE
Insurance company:_____
Authorization #:_____
Address: _____
_____
Insurance telephone:_____
Insurance ID#_____ Group#:_____
Subscriber:_____ Subscriber DOB:_____ M__ F____
Subscriber address:_____
_____
Employer: _____
Address: _____
Relationship of patient to subscriber: (Circle one) Self Spouse Child Other

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Person responsible for any balance not covered by
insurance:_____
Name
_____
Address

INSURANCE AUTHORIZATION AND ASSIGNMENT: I authorize the release of any medical or other information necessary to process claims and obtain authorization for treatment. I also assign to the provider all payments for medical services rendered to myself or my dependents. I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

_____
Signature of patient or responsible party Date