

Insurance Information:

PLEASE COMPLETE ALL INFORMATION FULLY

Primary Insurance:

Subscriber Name: _____ Relationship: _____

Subscriber Social Security Number: _____ Birth Date: _____

Subscriber Address: (if different) _____

Subscriber Employed by: _____

Business Telephone: _____

Business Address: _____

Insurance Company Name: _____

Subscriber ID # _____ Patient ID # _____

Group # _____ Telephone Number _____

Address _____

Is patient covered by any additional insurance? Yes or No

Secondary Insurance:

Subscriber Name: _____ Relationship: _____

Subscriber Social Security Number: _____ Birth Date: _____

Subscriber Address (if different) _____

Subscriber Employed by: _____

Business Telephone: _____

Business Address: _____

Insurance Company Name: _____

Subscriber ID # _____ Patient ID # _____

Group # _____ Telephone Number _____

Address _____

In cases of divorce, the parent who brings in the child/children for treatment is responsible for payment and for collecting from the other parent or attorneys.

Please provide insurance card(s) for copy. Thank You