**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) and driver's license for scanning. Thank You**