

PATIENT INSURANCE INFORMATION

DATE: _____

Patient Full Legal Name: _____
Last Name First MI Nickname

Address: _____
Street Address City State Zip Code

Telephone Number (Day) (____) ____ - ____

Social Security Number: _____

Insurer's Employer: _____

Insured Name as Printed _____
Last First MI

Relationship of Patient To Insured: _____

Insurance Company: _____

Insurance's Address: _____
Street Address City State Zip Code

Insurance Identification # _____ Group # _____

Customer Service Telephone Num. (____) ____ - ____

Member Telephone Number (____) ____ - ____

Did You Call Your Insurance Co To verify Coverage Before Your Apt Today?

YES _____ NO _____

Have You Read And Understand The Financial Policy?

YES _____ NO _____

Please sign below stating that you as the responsible party understand that if your insurance company does not pay within 30 days of treatment, you are responsible for your entire balance.

Signature Of Responsible Person _____ Date _____

Signature of Parent _____ Date _____

Signature of Witness _____ Date _____