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 Identifcation # _____ Group # _____

Customer Service Telephone Num. (___) ___-____

Member Telephone Number (___) ___-____

Did You Call Your Insurance Co To verifiy 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 responsile 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