PLEASE Verify your Insurance, before Appointment day!

PATIENT INSURANCE INFORMATION

Date:___________________

Patient Name: ____
Last Name First MI Nickname

Address: ____
Street Address City State Zip Code

DOB:___________________________ Email: ______________________________

Phone: (_____) ______________ Social Security Number:_____________________

Insured's Employer: ____

Insured Name: ______________________________ Relationship to Insured:___________
(as printed on card) Last First MI

Insurance Company: ____

Insurance Address: ____
Street City State Zip Code

Insured's ID #:_______________________ Group #: _________________________

Plan #: _____________________________ Payer ID #: ________________________

Insurance Phone: (____) _______________ Insured's Phone: (____) _____________

Insurance Effective Date: _______________ Maximum:_______ Minimum: _________

Did you call your insurance to verify covered before your appt today? __________

Have you read and understand the Financial Policy? __________

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 Party Date

______________________________ ____________
Signature of Parent Date

______________________________ ____________
Signature of Witness Date