

FOR LEGAL PERMISSION TO BILL, PLEASE FILL OUT COMPLETELY

**HEALTH INSURANCE INFORMATION**

PATIENT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**PRIMARY INSURANCE**

Insurance Co. Name \_\_\_\_\_ Effective Date \_\_\_\_\_

Name of Policy Holder(Insured) \_\_\_\_\_

Policy Holder (Insured ) Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Policy Holder (Insured) Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Phone \_\_\_\_\_

**SECONDARY INSURANCE**

Insurance Co. Name \_\_\_\_\_ Effective Date \_\_\_\_\_

Name of Policy Holder(Insured) \_\_\_\_\_

Policy Holder (Insured) Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Policy Holder (Insured) Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Phone \_\_\_\_\_

**RESPONSIBLE PARTY (FOR PORTION NOT COVERED BY INSURANCE)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE OF PATIENT (IF MINOR – PARENT SIGNATURE) REVIEWED/ENTERED BY**

\_\_\_\_\_