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 ________