



### INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY: \_\_\_\_\_ CO-PAY: \_\_\_\_\_

GROUP #: \_\_\_\_\_ SUBSCRIBER #: \_\_\_\_\_

INSURED FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DOB: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE #: \_\_\_\_\_ EXT: \_\_\_\_\_

ADVANCED DIRECTIVE?  YES  NO WHERE IS IT FILED? \_\_\_\_\_ (what medical facility?)

INSURED EMPLOYED BY: \_\_\_\_\_ BUSINESS ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP: \_\_\_\_\_ BUSINESS PHONE #: \_\_\_\_\_

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE?  YES  NO

INSURANCE COMPANY: \_\_\_\_\_ CO-PAY: \_\_\_\_\_

GROUP #: \_\_\_\_\_ SUBSCRIBER #: \_\_\_\_\_

INSURED FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DOB: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE #: \_\_\_\_\_ EXT: \_\_\_\_\_

INSURED EMPLOYED BY: \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP: \_\_\_\_\_

BUSINESS PHONE #: \_\_\_\_\_

EMPLOYMENT STATUS:  Employed  Unemployed  Full Time Student  Part Time Student  Retired

LAST DEGREE EARNED:  HIGH SCHOOL  COLLEGE  GRADUATE SCHOOL

OCCUPATION: \_\_\_\_\_ BUSINESS NAME: \_\_\_\_\_

BUSINESS PHONE: \_\_\_\_\_

DRIVERS LICENSE #: \_\_\_\_\_ STATE ISSUED: \_\_\_\_\_

IS THIS AN ACCIDENT?  YES  NO DATE OF INJURY \_\_\_\_\_ IS THIS A MOTOR VEHICLE ACCIDENT?  YES  NO

**YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT**

**By signing below, I attest that the information provided above is true and accurate**

**Signature of Insured / Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_