



**INSURANCE INFORMATION**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Primary Insurance Company:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Generally located on back of card)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Subscriber #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Relationship:  Self  Spouse / Partner Date of Birth: \_\_\_\_\_

**Effective Date:** \_\_\_\_\_

**Secondary Insurance Company:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Generally located on back of card)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Subscriber #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Relationship:  Self  Spouse / Partner Date of Birth: \_\_\_\_\_

**Effective Date:** \_\_\_\_\_

I understand the clinic will verify my insurance coverage but that this does not guarantee payment by the insurance company and I will be responsible for all charges.

\_\_\_\_\_  
Signature of Patient or representative

\_\_\_\_\_  
Date