Primary Insurance Information

Client Name: _____Birth Date: _____/_____/_____

Insurance Company: _____

Phone #: _____ Address: _____

City: _____ State: _____ Zip: _____

I.D. # _____ Group # _____

POLICY HOLDER PERSONAL INFORMATION

Relationship to patient: _____

Name: _____

Address: _____

City: _____ State: _____Zip: _____

Home Phone: _____ Birth Date: _____/_____/_____

Work Phone:_____ Sex: ____ Male ____ Female

Other Phone: _____

Employer: _____

Billing Information

Who is responsible for payment for this patient? Self/Patient: _____ Other: _____

Responsible Person: _____

Please complete the following information if different from policy holder information given above:

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Birth Date: _____/_____/_____

Marital Statue: Single_____ Married_____ Other _____

Gender: Male _____ Female _____

Employer: _____ School (school name, part time/full time): _____

Verbal Permission to share information with my billing service: Yes No Date of Initial Appointment: _____
Date of Telephone Call: _____