

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME OF COMPANY _____
BILLING ADDRESS _____
CITY _____ STATE _____ ZIP _____
INSURED'S NAME _____ SS# _____
BIRTHDATE _____ RELATIONSHIP TO PATIENT _____
POLICY # _____ GROUP # _____
EMPLOYER _____ EFFECTIVE DATE _____

SECONDARY INSURANCE

NAME OF COMPANY _____
BILLING ADDRESS _____
CITY _____ STATE _____ ZIP _____
INSURED'S NAME _____ SS# _____
BIRTHDATE _____ RELATIONSHIP TO PATIENT _____
POLICY # _____ GROUP # _____
EMPLOYER _____ EFFECTIVE DATE _____

WE MUST HAVE A COPY OF YOUR INSURANCE CARDS IN YOUR CHART