INSURANCE REGISTRATION

Insurance cards present for scanning

PLEASE NOTE:

This is a confidential record of your medical history and will be kept in the office. Information contained here will not be released to any person except when you have authorized us to do so.

Name:____ Date: ____________________

PRIMARY INSURANCE Insurance Name:____

Insurance Address ____ Phone # ___________________

Subscriber ID#____________ Group # __________ Plan # _________ Coverage Begin Date: __________

Annual Deductible__________ Co-payment_________ Insureds Name _____________________________

Insureds Date of Birth_____________ Insureds Sex M / F Insureds Phone #____________________

Insureds Social Security # ____________________ Insureds Address ____________________________

City ______________________________________ State ___________________ Zip Code _____________

Insureds Employer ________________________________Employer's Phone # _____________________

Employer's Address ________________________________City _________ State ______Zip Code _____

SECONDARY INSURANCE Insurance Name:____

Insurance Address ____ Phone # ___________________

Subscriber ID#____________ Group # __________ Plan # _________ Coverage Begin Date: __________

Annual Deductible__________ Co-payment_________ Insureds Name _____________________________

Insureds Date of Birth_____________ Insureds Sex M / F Insureds Phone #____________________

Insureds Social Security # ____________________ Insureds Address ____________________________

City ______________________________________ State ___________________ Zip Code _____________

Insureds Employer ________________________________Employer's Phone # _____________________

Employer's Address ________________________________City _________ State ______Zip Code _____

I authorize payment of medical benefits be made directly to the physician provider for services rendered. I am financially responsible for all co-payments and non-covered services. I authorize any insurance company, organization, employer, hospital, physician or pharmacist to release any information to this claim and the expenses reported, either by mail, fax or electronically.

Date:________________________ Signature (Insured or Authorized): ____