INSURANCE INFORMATION

PATIENT NAME_____DOB_____

NAME OF INSURANCE_____

POLICY #_____GROUP #_____

POLICY HOLDER'S NAME_____MALE FEMALE

POLICY HOLDER'S ADDRESS_____

POLICY HOLDER'S DATE OF BIRTH_____RELATIONSHIP TO PATIENT_____

WHAT IS YOUR COPAY FOR A SPECIALIST? _____DOES YOUR INSURANCE REQUIRE A REFERRAL YES NO

WE RECOMMEND AN ANNUAL VISIT WITH YOUR PRIMARY CARE PHYSICIAN.

HAVE YOU SEEN YOUR PRIMARY CARE PHYSICIAN WITHIN THE PAST YEAR? YES NO

FOR THE PURPOSE OF INFORMING US HOW WE SHOULD EXPECT PAYMENT, PLEASE ANSWER THESE QUESTIONS.

DO YOU HAVE A DEDUCTIBLE YES NO MONTH DEDUCTIBLE STARTS_____

HOW MUCH IS YOUR DEDUCTIBLE_____HOW MUCH HAS BEEN MET_____

I understand that if I have a deductible, I am responsible for paying the allowed amount that the insurance may require for today's visit.

Signature Date