Client Insurance Information

Client/Patient Information

Name*: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Other _____

Address*: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone _____

Cell Phone _____ Best number to contact you: ☐ Home ☐ Work ☐ Cell

DOB*: ____/____/____ SSN# _____

Responsible/Insured Party

Name*: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Other _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone _____

Cell Phone _____ Best number to contact you: ☐ Home ☐ Work ☐ Cell

DOB*: ____/____/____ SSN# _____

Insurance Information

Insurance Company*: _____ **Type of Plan** * ☐ HMO ☐ PPO

Name of Medical Group/IPA (If HMO)*: _____

Insurance Company/Medical Group Phone :(See back of the card)_____

Member ID Number*: _____ Group Number: _____

Please attach a copy of your insurance card (front and back) to this form.

-------***DO YOU HAVE ANY ADDITIONAL/SECONDARY INSURANCE?*** ☐ ***Yes*** ☐ ***No*** ***IF YES, COMPLETE THE FOLLOWING***-----

Secondary Insurance Company: _____ Type of Plan ☐ HMO ☐ PPO

Name of Medical Group/IPA (If HMO): _____

Insurance Company/Medical Group Phone: (See back of the card) _____

Member ID Number: _____ Group Number: _____

(*Mandatory Fields) Signature*: _____

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