



INSURANCE FORM (only complete this form if you would like us to bill your insurance.)

Date: _____

Name: _____

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

Home Phone: _____ Business Phone: _____ E-mail (optional): _____

Social Security Number: _____ Date of Birth: _____ Age: _____

Responsible Party: _____

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

Employer: _____

Emergency Contact Name: _____

Phone: () _____ Address: _____

Will your services be billed to health insurance or Medicare? _____

If so, complete the following:

Insured person: _____ Relationship: _____

Ins. Co. name, address & phone: _____

Group no. _____ ID no. _____ Insured employer: _____

Do you have any other health insurance? _____ If yes, please specify: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:

I authorize the release of any medical or other information necessary to process insurance claims. I request payment of benefits be made to this office.

Signature: _____ Date: _____