INSURANCE INFORMATION

DATE: _____ PHYSICIAN: _____

Are you required to choose a primary care physician? YES / NO

If YES, have you notified your insurance company of your choice: YES / NO

POLICY HOLDER: _____

POLICY HOLDER SSN: _____

POLICY HOLDER DATE OF BIRTH: _____

POLICY HOLDER ADDRESS:_____

POLICY HOLDER CITY/STATE/ZIP: _____

SEND PT STATEMENT TO THIS ADDRESS? YES / NO

HOME TELEPHONE: _____ **CELL:** _____

EMPLOYER: _____ **OR, SELF POLICY? YES / NO**

INSURANCE COMPANY:_____

MEMBER ID: _____ **GROUP:** _____

EFFECTIVE DATE OF POLICY: _____

LIST ALL CHILDREN COVERED BY THIS INSURANCE THAT COME TO THIS OFFICE:

Legal Name (as listed with insurance) **Date of Birth**

1._____
2._____
3._____
4._____

In the event that claims are denied due to the lack of information provided to my physician (i.e., not selecting a primary care physician, not furnishing accurate information before the filing deadline), I understand that I will be fully responsible for all charges.

Parent/Guardian Signature:_____Date:_____

Fax to: (281) 499-7180