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INSURANCE (page 5 of 5)

Patient Name: _____Insurance Holder: _____
(if different from patient)

Insurance ID #:_____ Group #: _____

Date of Birth: _____ Insured Date of Birth: _____

Insurance Co.: _____Telephone #: _____

Claims Address: _____

Clients relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY INSURANCE (IF APPLICABLE)

Patient Name: _____ Insurance Holder: _____
(if different from patient)

Insured ID #: _____ Group #: _____

Date of Birth: _____ Insured Date of Birth: _____

Insurance Co.: _____Telephone #: _____

Claims Address: _____

Clients relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

PLEASE ATTACH AND SEND COPIES OF YOUR INSURANCE CARD(S) FRONT AND BACK WITH YOUR FILLED OUT AND SIGNED INTAKE FORMS. THANK YOU.

NOTES:

Signature: _____ Date: _____