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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: __________________________