

Patient Insurance Form

Patient Name: _____ Date: _____
(last) (first) (M.I.)

Address: _____
(Street) (city) (State) (Zip)

Primary Insurance Company

Name: _____

Address: _____
(Street) (city) (State) (zip)

Phone #: _____

I.D. #: _____ Group #: _____

Secondary Insurance Company

Name: _____
(Street) (city) (State) (zip)

Phone #: _____

I.D. #: _____ Group #: _____

I hereby authorize any and all insurance benefits to be paid directly to Dr. _____.
I understand that I am financially responsible for my charges regardless of insurance benefits and I am also responsible for any collection, legal or any other costs incurred should they be necessary on my account because of non-payment. I hereby authorize the release of any medical records and other information for the process of insurance benefits for any medical/surgical services rendered.

Signature: _____ Date: _____

If you do not have health insurance please write, NO HEALTH

INSURANCE. _____

Patient Signature _____ *Date:* _____

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