INSURANCE INFORMATION

Primary Insurance Patient's Insurance ID#: _____

Subscriber (whose job provides plan?):_____
(Last) (First) (MI)

Subscriber's Date of Birth: _____ Sex: M or F Subscriber's Social Security #: _____

Insurance Company: _____ ID #:_____ Group#:_____

Second Insurance? Y or N Patient's Insurance ID#: _____

Subscriber:_____
(Last) (First) (MI)

Subscriber's Date of Birth: _____ Sex: M or F Subscriber's Social Security #:_____

Insurance Company: _____ ID #: _____ Group #: _____

If there is a third plan, please put information on back. **Is this related to a Motor Vehicle Accident or Worker's Comp?** Y/N Ultimately, who is responsible for the bill (the Guarantor)? _____

Address:_____

____**AUTHORIZATION TO PAY INSURANCE BENEFITS/CONSENT FOR TREATMENT If required, I hereby authorize payment directly to the physician responsible for my care. I understand that I am financially responsible to my physician for all fees incurred and for fees not covered by this authorization. I authorize the release of my medical information to my third-party payor in order to obtain payment. I hereby authorize the physician to release any medical information required for my examination or treatment. I understand that payment is expected at rendering of services unless other arrangements have been made. I hereby also consent to medical treatment for my present condition or injury, and for any illness or injury incurred at any time after the date noted below. I have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient, authorized to furnish the information requested. I understand that even if I have some type of insurance coverage, I am responsible for payment of services.**

_____ _____
Signature of Patient or Parent or Legal Guardian Date