

## INSURANCE INFORMATION

### PRIMARY INSURANCE

INSURANCE COMPANY: \_\_\_\_\_ CO-PAY: \_\_\_\_\_  
GROUP #: \_\_\_\_\_ SUBSCRIBER #: \_\_\_\_\_  
INSURED FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ MI: \_\_\_\_\_  
SOCIAL SECURITY #: \_\_\_\_\_ DOB: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PHONE #: \_\_\_\_\_ EXT: \_\_\_\_\_  
ADVANCED DIRECTIVE?  YES  NO WHERE IS IT FILED? \_\_\_\_\_ (what medical facility?)  
INSURED EMPLOYED BY: \_\_\_\_\_ BUSINESS ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP: \_\_\_\_\_ BUSINESS PHONE #: \_\_\_\_\_

### ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE?  YES  NO  
INSURANCE COMPANY: \_\_\_\_\_ CO-PAY: \_\_\_\_\_  
GROUP #: \_\_\_\_\_ SUBSCRIBER #: \_\_\_\_\_  
INSURED FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_ MI: \_\_\_\_\_  
SOCIAL SECURITY #: \_\_\_\_\_ DOB: \_\_\_\_\_ RELATION TO PATIENT: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PHONE #: \_\_\_\_\_ EXT: \_\_\_\_\_  
INSURED EMPLOYED BY: \_\_\_\_\_  
BUSINESS ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE \_\_\_\_\_ ZIP: \_\_\_\_\_  
BUSINESS PHONE #: \_\_\_\_\_

EMPLOYMENT STATUS:  Employed  Unemployed  Full Time Student  Part Time Student  Retired  
LAST DEGREE EARNED:  HIGH SCHOOL  COLLEGE  GRADUATE SCHOOL  
OCCUPATION: \_\_\_\_\_ BUSINESS NAME: \_\_\_\_\_  
BUSINESS PHONE: \_\_\_\_\_

DRIVERS LICENSE #: \_\_\_\_\_ STATE ISSUED: \_\_\_\_\_

IS THIS AN ACCIDENT?  YES  NO DATE OF INJURY \_\_\_\_\_ IS THIS A MOTOR VEHICLE ACCIDENT?  
 YES  NO

**YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT**  
**By signing below, I attest that the information provided above is true and accurate**

**Signature of Insured / Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_