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Insurance Information

Name of Insured: _____ Date of Birth: _____
Address: _____ City/State/Zip: _____
Home phone: _____ Work phone: _____ SS# _____
Employed by: _____
Address: _____ City/State/Zip: _____
Insurance Contact person or department: _____
Your relationship to the insured: _____
If patient is a minor, name and address of responsible party for
payment: _____
Relationship: _____

Primary Insurance Company

Name: _____
Address: _____ City/State/Zip: _____
Phone #: _____ **Group# :** _____ **Policy# :** _____
Do you have secondary insurance coverage? Yes ___ No ___ (If so, please fill out the information below)

Secondary Insurance Company

Name: _____
Address: _____ City/State/Zip: _____
Phone #: _____ **Group# :** _____ **Policy# :** _____

I hereby certify that the above information is correct. I understand that insurance may not cover all costs of treatment and I agree to pay my balance prior to or by the date of service. A \$50.00 fee is charged for appointments canceled or broken without 48 hours advance notice.

Signature: _____ **Date:** _____