

INSURANCE INFORMATION

INSURANCE COMPANY: _____

INSURANCE ID NUMBER: _____

INSURANCE GROUP NUMBER: _____

THIS IS THE ONLY INSURANCE I HAVE: _____ YES _____ NO

THIS POLICY IS THROUGH MY EMPLOYER: _____ YES _____ NO

*** IF YOU ANSWERED YES TO BOTH QUESTIONS DO NOT ***
COMPLETE ANY MORE QUESTIONS BUT SIGN ON LINE
AT THE BOTTO!

*** IF YOU ANSWERED NO TO EITHER QUESTION ABOVE ***
COMPLETE THE REMAINDER OF THE FORM AND SIGN
AT THE BOTTOM

NAME OF POLICY HOLDER: _____
FIRST INITIAL LAST

POLICY HOLDER'S SEX: _____ MALE _____ FEMALE

POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S ADDRESS: _____
STREET

CITY STATE ZIP CODE

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

POLICY HOLDER'S PHONE NUMBER: _____

POLICY HOLDER'S EMPLOYER: _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER: _____ WIFE _____ HUSBAND _____ CHILD

DO YOU HAVE ANOTHER HEALTH INSURANCE COMPANY: _____ YES _____ NO

THE NAME OF THAT INSURANCE COMPANY: _____

INSURANCE ID NUMBER: _____

INSURANCE GROUP NUMBER: _____

NAME OF POLICY HOLDER: _____

FAMILY HEALTHCARE HAS MY PERMISSION TO BILL THE INSURANCE COMPANIES LISTED ABOVE FOR SERVICES RENDERED TO ME OR MY DEPENDENT. I AM CERTIFYING THAT THE INSURANCE INFORMATION IS ACCURATE.

DATE

SIGNATURE
PATIENT OR PARENT/GUARDIAN