

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 bottom**

***** 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

IF YES, NAME OF 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