INSURANCE INFORMATION UPDATE

FAILURE TO PROVIDE ALL INSURANCE INFORMATION LISTED BELOW ALONG WITH A COPY OF YOUR INSURANCE CARD WILL MAKE ALL CHARGES PATIENT RESPONSIBILITY.

PRIMARY INSURANCE:

Insurance Company Name:_____

Insurance Address:_____City_____State_____Zip_____

Does your insurance require you to choose a Primary Care Physician? YES_____ NO_____

If yes, which doctor did you sign your child up with?_____

Subscribers Name:_____Subscribers Date of Birth_____

Subscribers Social Security #:_____

Group Number:_____ Insurance ID #_____

Employer:_____Employer Phone #_____

Effective date of this insurance:_____

List all family members covered by this insurance:_____
Does this insurance replace the old primary insurance? YES_____ NO_____
Do we need to rebill any old charges to this new insurance? YES_____ NO_____

SECONDARY INSURANCE:

Insurance Company Name:_____

Insurance Address:_____City_____State_____Zip_____

Does this insurance require you to choose a Primary Care Physician? YES_____NO_____

If yes, which doctor did you sign your child up with?_____

Subscribers Name:_____Subscribers Date of Birth:_____

Subscribers Social Security #:_____

Group Number:_____ Insurance ID#_____

Employer:_____Employer Phone Number:_____

Effective Date of this Insurance:_____
List all family members covered by this insurance:_____
Does this insurance replace the old insurance? YES_____NO_____
Do we need to rebill any old charges to this new insurance? YES_____NO_____