

INSURANCE HOLDER INFORMATION

Date: _____

Name of Primary Insurance Company: _____

Name of Insured Employee: _____

Birth Date: _____

Employer: _____ Group Number: _____

Insured Social Security # : _____ ID# : _____

Insurance Company's Address: _____

City, State and Zip: _____

Phone: (____) _____

Insured Dependents Names: _____

Name of Secondary Insurance Company: _____

Name of Insured Employee: _____

Birth Date: _____

Employer: _____ Group Number: _____

Insured Social Security # : _____ ID# : _____

Insurance Company's Address: _____

City, State and Zip: _____

Phone: (____) _____

Insured Dependents Names: _____

FT College Student Y/N **Name/Address of School:** _____

Filing of insurance is a courtesy we happily extend to our patients. Please be aware any insurance estimates quoted are only an estimate and not a guarantee of benefits. You are ultimately responsible for all charges incurred in this office.