Insurance Information

Patient's Name: _____ Today's Date: _____
First Middle Last

[Primary Insurance]
Name of Insurance Company:
_____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Group Number: _____ Policy ID Number: _____

[Secondary Insurance]
Name of Insurance Company:
_____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Group Number: _____ Policy ID Number: _____

Did your injury happen on the job? Yes No
If yes, on what date did the injury occur? _____
Did you report the accident to your employer? Yes No

OUR OFFICE WILL FILE INSURANCE FOR ALL REIMBURSABLE SERVICE, TO BOTH YOUR PRIMARY AND SECONDARY INSURANCE CARRIERS. ALL COPAYMENTS AND DEDUCTIBLES WILL BE COLLECTED AT THE TIME OF SERVICE.

Method of Payment for Today's Visit: ___Cash ___Check ___Visa/MC

Signature of Patient or Responsible Party: _____

Date: _____

I authorize the release of any medical information.

Signed: _____
(Patient or responsible party)

Date:

I authorize payment of medical and surgical benefits to _____, MD.

Signed: _____
(Patient or responsible party)

Date:

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