PRIMARY INSURANCE

Insurance Company_____

Insurance Company Address_____

Group Number_____ ID Number_____Insured's Name_____

Insured's SS#_____Relationship (circle one) Self Spouse Child

Insured's Birthday_____ Insured's Employer_____

OTHER INSURANCE SECONDARY

Insurance Company_____

Insurance Company Address_____

Group Number_____ ID Number_____Insured's Name_____

Insured's SS#_____ Relationship (circle one) Self Spouse Child

Insured's Birthday_____ Insured's Employer_____

EMPLOYMENT INFORMATION

Company_____Occupation_____

Employer's Address_____Phone_____

City, State, Zip Code_____

SIGNATURE AND AUTHORIZATION

I understand and agree that regardless of any insurance status, I am ultimately responsible for the balance on my account for any professional services, including co-insurance, deductible and non-covered services. I have read all the information on both sides of this sheet and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or above information. I authorize the release of any information necessary to process this claim and request payment to the party who accepts assignment.

SIGNED_____ DATE_____