MR# ___________

Insurance Information

Patient's Name ____ Today's Date: __________

First Middle Last

[Primary Insurance] please complete section

Name of Insurance Company: ____

Address: ____

City: ____ State: __________ Zip: ____________

Insured's Name: ______________________________ DOB: ____________________________

Group Number: ______________________________ Policy ID Number: __________________

Was this insurance purchased through Healthcare Exchange (ObamaCare)? Yes No

[Secondary Insurance] please complete section

Name of Insurance Company: ____

Address: ____

City: ______________________________________ State: __________ Zip: _____________

Insured's Name: ______________________________ DOB: _____________________________

Group Number: ______________________________ Policy ID Number: __________________

Was this an injury or accident? Yes No If yes, describe: _____________________________

Did you injury happen on the job? Yes No If yes, date the injury occurred? ________________

Did you report the accident to your employer? Yes No

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. **Please remember that you are responsible for all deductible, copay, and no covered service amounts. See our complete financial policy for details.**

Method of Payment for Today's Visit: ____Cash ____Check ____Visa/MC