INSURED/INSURANCE INFORMATION

For Insurance Users Only

(Please present insurance card)

PRIMARY INSURANCE: _____

Insured _____ Gender: ❑ Female ❑ Male

Address _____

_____

Authorization No. _____

Relationship to client: ❑ Self ❑ Spouse ❑ Other _____

Insured Date of Birth _____

SECONDARY INSURANCE: _____

Insured _____ Gender: ❑ Female ❑ Male

Address _____

_____

Authorization No. _____

Relationship to client: ❑ Self ❑ Spouse ❑ Other _____

Insured Date of Birth _____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature _____ Date____/____/____

I authorize payment of medical benefits to the undersigned physician or supplier for services described on claims.

Signature _____ Date____/____/____