

## Insurance Information

Name: \_\_\_\_\_ M/F Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance 1: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance 2: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

## Release and Assignment

I hereby authorize release of all information to all my insurance companies. I also authorize and request that my insurance company send payment directly to my doctor.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_