

Insurance Information:

Your Social Security: (_____ - ____ - _____)

Primary Medical Insurance Carrier: _____ Policy #: _____

Secondary Insurance Carrier (if applicable): _____ Policy #: _____

Is Medical Insurance through YOUR Employer Yes No

If NO, name person who holds insurance: _____ Relationship to you: _____

Employer of Insurance Holder: _____ Occupation: _____

Employer Address: _____ City _____

Auto Insurance or Worker's Compensation Information Only:	
Name of Company: _____	Date of Injury: ____/____/____
Address: _____	City: _____ Zip: _____
Claim # _____	Claim Adjuster Name: _____
Telephone: () _____	
Person to contact in case of emergency:	
Name: _____	Number: _____
Name: _____	Number: _____

Benefit information, which is received from the insured's insurance company, does not constitute a guarantee of payment. Therefore I understand it is my responsibility to also obtain benefit coverage information from my insurance company. I understand and agree that, regardless of my insurance status, I am ultimately responsible for balance on my account for and professional services rendered. I certify the above information is true and correct to the best of my knowledge. I will notify you of any changes in my health status and above information.

Signature: _____ Date: _____

Parent (if minor): _____ Date: _____