Reset Form

Practice name

INSURANCE INFORMATION FORM

(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status: ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:		Home phone no.:	
P.O. box:	City:		State:		ZIP Code:
Occupation:	Employer:			Employer phone no.:	

INSURANCE INFORMATION

(If possible, please attach a copy of your insurance card.)

Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.:	
Occupation:	Employer:	Employer address:		Employer phone no.:	
Is this patient covered by insurance? ❑ Yes ❑ No		Does an Employee Assistance Program (EAP) cover this patient?	❑ Yes	If "yes,' how many visits?	
Please indicate primary insurance	❑ Medicare	❑ Medicaid	❑ Blue Cross /Blue Shield	❑ Aetna	
❑ Cigna	❑ Harvard Pilgrim	❑ Tufts	❑ United	❑ Other *(please specifiy)*	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other (please specifiy)	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other *(please specifiy)*	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to _____ (name of practice). I understand that I am financially responsible for any balance. I also authorize _____ (name of practice) or insurance company to release any information required to process my claims.

Patient/Guardian signature / / *Date*

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