Insurance Information

Please complete the * lines on this form. Upon completion, present to Registrar with insurance card for copying. If no card available, then complete entire form.

***Patient Name:** _____ Chart #: _____
Completed by Registrar

***Primary Insurance Company Name:** _____

Address: _____

Phone #: _____ Type of Insurance: _____

Policy #: _____

Group Name : _____ Group Number: _____

***Insured's (Policy Holder as it appears on card) Name:** _____

***Insured's Date of Birth:** _____/_____/_____ ***Insured's Gender: Male/ Female**

***Patient's Relationship to Insured:** Self Child Spouse Other _____

***Secondary Insurance Company Name:** _____

Address: _____

Phone #: _____ Type of Insurance: _____

Policy #: _____

Group Name : _____ Group Number: _____

***Insured's (Policy Holder as it appears on card) Name:** _____

***Insured's Date of Birth:** _____/_____/_____ ***Insured's Gender: Male/ Female**

***Patient's Relationship to Insured:** Self Child Spouse Other _____

***Vision Insurance Company Name:** _____

Address: _____

Phone #: _____ Type of Insurance: _____

Policy #: _____

Group Name : _____ Group Number: _____

***Insured's (Policy Holder as it appears on card) Name:** _____

***Insured's Date of Birth:** _____/_____/_____ ***Insured's Gender: Male/ Female**

***Patient's Relationship to Insured:** Self Child Spouse Other _____
