INSURANCE HOLDER INFORMATION Date: _____

Name of Primary Insurance Company: _____

Name of Insured Employee: _____ _____

Birth Date: _____

Employer: _____ Group Number: _____

Insured Social Security # : _____ ID# : _____

Insurance Company's Address: _____ _____

City, State and Zip: _____

Phone: (_____) _____

Insured Dependents Names: _____

Name of Secondary Insurance Company: _____

Name of Insured Employee: _____ _____

Birth Date: _____

Employer: _____ Group Number: _____

Insured Social Security # : _____ ID# : _____

Insurance Company's Address: _____ _____

City, State and Zip: _____

Phone: (_____) _____

Insured Dependents Names: _____

FT College Student Y/N Name/Address of School: _____

Filing of insurance is a courtesy we happily extend to our patients. Please be aware any insurance estimates quoted are only an estimate and not a guarantee of benefits. You are ultimately responsible for all charges incurred in this office.