Networked Health Information

Last Update:______________

Please complete the following information ao that we can process your insurance or billing statements for you. Our office will do everything possible to help you collect your insurance but we must have accurate information.
Your insurance company may have specific requirements that you must follow for complete reimbursement. **Read your policy carefully.**

Patient Last Name:__________________________ M. Init: _____ First Name ___________________________

Billing Address: ____

City: ______________________ State_____ Zip _________

If you have an alternate mailing address other than the billing address enter it below:

Patient Last Name:____________________ M. Init: _____ First Name ___________________

Billing Address: ____

City: ______________________ State_____ Zip _________

Evening Phone: (___)____-________

Day Phone: (___)____-________

Cell Phone: (___)____-________

Social Security No: _____-_____-_____

Date of Birth: ______________________

Referred By: _______________________

Policy Holder Information For The First Insurance To Bill

First Name of Policy Holder: ______________________________

Middle Name: ______________________________

Last Name: ______________________________

Social Security Number: ______________________________

Employers Name: ______________________________

Street: ______________________________

City: ______________________________

State: ____________________ Zip: ____________________

Employer Phone (_____) ______- ____________________

Group Indentification number: ______________________________

Insurance Company: ______________ Phone: (____) _____-__________

Address: ______________________________

____

City: _______________________ State: ______ Zip: __________

Group Name: ______________________________

Type of Plan: ______________________________

Indentification Number: ______________________________

Insurance Begin Date: ________________ End Date: ______________

Policy Holder Information For The Second Insurance To Bill

First Name of Policy Holder: ______________________________

Middle Name: ______________________________

Last Name: ______________________________

Social Security Number: ______________________________

Employers Name: ______________________________

Street: ______________________________

City: ______________________________

State: ____________________ Zip: ____________________

Employer Phone (_____) ______- ____________________

Group Indentification number: ______________________________

Insurance Company: ______________ Phone: (____) _____-__________

Address: ______________________________

____

City: _______________________ State: ______ Zip: __________

Group Name: ______________________________

Type of Plan: ______________________________

Indentification Number: ______________________________

Insurance Begin Date: ________________ End Date: ______________

Please read and sign both sections below:

Your insurance company may have special requirements for medical care reimbursement. this may include advance precertification for office procedures and hospital admission. We will be glad to assist you with this; however, the final responsibility is yours. **Remember you may have to call your insurance agent or company.**

I understand that it is my responsibility as a patient to fulfill my insurance requirements for treatment.

Date: ________________ Signature: ____

I hereby authorize payment directly to my health care provider for surgical and/or medical benefits for their services as described in the insurance forms prepared by them. I authorize the release of medical information required to process my insurance.

Date: ________________ Signature: ____