

INSURANCE INTAKE FORM

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Verify Benefits _____

PATIENT Name _____ Address _____ _____ Employer _____	Date of Birth _____ Phone (Home) _____ Phone (Work) _____ Single ____ Married ____ Male ____ Female _____ ID# _____ Group# _____ Phone# _____
PRIMARY PLAN INFORMATION Plan Name _____ Address _____ _____	INSURED INFORMATION, IF OTHER THAN YOURSELF Name _____ Address _____ _____
RELATIONSHIP TO INSURED Self ____ Child ____ Spouse ____ Other _____	Date of Birth _____ ID# or Claim# _____ Adjuster's Name _____ Date of Injury _____ Name of Insured _____
SECONDARY INSURANCE INFORMATION Plan Name _____ Address _____ _____ Phone# _____	

I agree to the release of any medical information my health insurance may need in order to process payment. I assign some benefits to be paid to the above named provider. In the event that my insurance coverage expires or denies payment.

I understand that I am personally responsible for all fees incurred unless other arrangements have been made.

Signature _____ Date _____