



# INSURANCE INFORMATION

## RELEASE AND RESPONSIBILITY

PATIENT NAME: \_\_\_\_\_ SEX: \_\_\_\_\_ DOB: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

PATIENT SS#: \_\_\_\_\_ DRIVERS LICENSE #: \_\_\_\_\_ STATE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

RACE: \_\_\_\_\_ PREFERRED LANGUAGE: \_\_\_\_\_

MEDICAL INSURANCE: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ SUBSCRIBER DOB: \_\_\_\_\_

SUBSCRIBER SS#: \_\_\_\_\_ RELATIONSHIP TO SUBSCRIBER: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE #: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

RESPONSIBLE PARTY NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE #: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

I AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION TO THE FOLLOWING PEOPLE:

NAME: \_\_\_\_\_ NAME: \_\_\_\_\_

NAME: \_\_\_\_\_ NAME: \_\_\_\_\_

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE COVERAGE.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_