EXISTING PATIENT NEW INSURANCE INFORMATION

DATE: _____

PATIENT NAME: _____

PATIENT DOB: _____

PATIENT SS#: _____

MINOR: □ Y □ N

AGE: _____

ADDRESS: _____

_____

CITY: _____

STATE: _____

ZIP: _____

PARENT/RESPONSIBLE PARTY NAME: _____

PROVIDER(S)/ACCT #: _____

GENDER: □ M □ F □ Transgender

CELL: _____

HOME: _____

WORK: _____

EMAIL: _____

INSURANCE STATUS: □ NEW □ SAME

INSURANCE COMPANY: _____

3RD PARTY PAYER: _____

PRIMARY HOLDER: _____

EMPLOYER: _____

MEMBER ID#: _____

POLICY HOLDER GENDER: □ M □ F □ Transgender

RELATIONSHIP TO PATIENT: _____

TYPE: □ HMO □ PPO

INS TEL#: _____

3RD PARTY TEL#: _____

DOB: _____

SS#: _____

GROUP #: _____

FOR OFFICE USE ONLY

EFFECTIVE: _____ VERIFICATION DATE: _____

CO PAY: $_____ # OF VISITS: _____ PRE-EXISTING WAIVED: -

DEDUCTIBLE: $_____ DEDUCTIBLE MET: -

AUTH. REQ: - #: _____ EFFECTIVE DATES: _____ *TO* _____ # OF VISITS: _____

SEND CLAIMS TO: _____

REF #: _____

NOTES: _____

DATE UPDATED IN SYSTEM: _____

UPDATED BY: _____