INSURANCE INFORMATION

Patient Last Name	Firs	st Name	Middle
INSURANCE TYPE Check all thos	e that apply		
SELF INSURANCE (CONSUMER DIRECTED)	EMPLOYER SPONSORED (PRIVATE SECTORS)	GOVERNMENTS (PUBLIC SECTORS)	OTHER TYPES
 □ Personal Health Insurance (not sponsored by employer) □ Health Savings Account (HSA) □ Medicare Savings Account (MSA) □ Other 	 □ Group Health Insurance □ Self-Funded Benefit Plan □ Private Schools □ Health Reimbursement Arrangement (HRA) 	 □ Medicare Part B □ Medicare Part C □ Medicaid □ Municipal (city, state, etc.) □ Other 	□ Personal Injury (Auto, etc.)□ Workers' Compensation□ Church□ Other
INSURANCE We need a copy of yo	our card(s) for our records.		
Insurance Company Insured's Name			
Insurance Company Insured's Name			
Insurance Company Insured's Name			
RESPONSIBLE PARTY Complete Responsible Party Relationship to Patient		•	
Home Address			Apt#
City		State	Zip
Home Phone #		Work Phone #	
Employer Name		Occupation ————	
I authorize the release of any medical or private benefits either to myself or at any time by written notice.		ary to process my claims. I al	,
x			 Date
	MY FINANCIAL R	RESPONSIBILITY	
I certify that the above information is for by my insurance. I am also response required by my insurance plan.	correct. I understand that I	am personally financially	- · · · · · · · · · · · · · · · · · · ·
xSignature of patient or person acting	on patient's behalf		 Date