Insurance Information

Date:____________________

Medical Insurance ________________________
Subscriber Name _________________________
Subscriber SSN __________________________
Subscriber Birth Date ______________________
Patient Name ____________________________
Relation to Subscriber _____________________
ID # ___________________________________
Policy # ________________________________
(Request copy of card)

Vision Benefit ___________________________
*If different than above on medical, please fill out below
Subscriber Name ________________________
Subscriber SSN __________________________
Subscriber Birth Date ______________________
Patient Name ____________________________
Relation to Subscriber ______________________
(Request copy of card)

Authorization and Release: I authorize release of any information including the diagnoses and treatment records of any examination rendered to me or my child during the period of such care to third party payers and/or other health care practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance company may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X____ _________
Signature of Responsible Party Date