Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:_____

☐ Male ☐Female ☐Married ☐Single ☐Other

Social Security #_____Birth Date:_____

Phone (Home):_____(Work):_____Ext:____ Best time to call:_____

Address:_____
Street Apt. #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment.

Employer Name_____Occupation:_____

Address:_____
Street City State Zip Code

Phone:_____

Insurance Information

Primary insurance

Name of the insured:_____Is the insured a patient?_____

Insured's Birth Date:_____ID#_____Group #_____

Insured's Address:_____
Street Apt.#

_____
City, State Zip Code

Insured's Employer Name:_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

_____

Insurance phone number: (_____)_____

Secondary insurance

Name of the insured:_____Is the insured a patient?_____

Insured's Birth Date:_____ID#_____Group #_____

Insured's Address:_____
Street Apt.#

_____
City, State Zip Code

Insured's Employer Name:_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

_____

Insurance phone number: (_____)_____