Kenneth M. Klebanow, MD & Associates P.A.

Insurance update

Patient Information

Last name: _____ First Name: _____

Date of Birth: _____

To submit claims correctly, we need to scan all your children's insurance cards.

Siblings in practice:

Name:_____Date of Birth:_____

Covered under this policy? Yes ☐ No ☐

Name:_____Date of Birth:_____

Covered under this policy? Yes ☐ No ☐

Name:_____Date of Birth:_____

Covered under this policy? Yes ☐ No ☐

Insurance Information

Name of **Primary** Insurance Company: _____

Policy #:_____ Group #: _____

Insurance Address : _____

Policy Holder's Name: _____ Date of Birth: _____

Employer: _____

Name of **Secondary** Insurance Company: _____

Policy #:_____ Group #: _____

Insurance Address : _____

Policy Holder's Name: _____ Date of Birth: _____

Employer: _____

Guardian's Information

Parent's Status: Married Separated Divorced Single Partner Widowed

Last Name: _____ First Name: _____

Relationship to patient : _____ Child's primary address? Yes ☐ No ☐

Address : _____

Primary Phone #: _____ Work #: _____

Last Name: _____ First Name: _____

Relationship to patient : _____ Child's Primary address? Yes ☐ No ☐

Address : _____

Primary Phone #: _____ Work #: _____

Signature: _____ Date: _____