Secondary Insurance

Complete either section A or B

A) My Family DOES NOT have a secondary insurance policy.

Parent or Guardian Name: _____ Date: _____

Parent or Guardian Signature: _____

B) My Family DOES have a secondary insurance policy.

Patients covered by secondary policy:

Name: _____ DOB: _____/_____/_____ Sex: M or F

Name: _____ DOB: _____/_____/_____ Sex: M or F

Name: _____ DOB: ____/_____/_____ Sex: M or F

Name: _____ DOB: ____/_____/_____ Sex: M or F

Insurance Information:

Secondary Insurance: _____ Policy ID #: _____

Policy Holder Name_____ DOB: _____/_____/_____

Note: We will bill your secondary insurance one time. If payment is not received within 30 days the visit balance will be applied to your account.

Parent or Guardian Name: _____ Date: _____

Parent or Guardian Signature: _____