INSURANCE FILE RECORD

Name of patient_____
Last First Middle

Address_____

City_____ State_____ Zip code_____

Phone # (Home) _____Phone # (cell)_____

Address_____

POLICY HOLDER INFORMATION

Name of Subscriber_____

Relationship to Patient_____

Date of Birth _____Social Security Number_____

Employer_____

Insurance Co._____

Ins. Claim Address_____

Ins. Co. Phone #_____Policy #_____

ADDITIONAL COVERAGE

Does patient have other insurance: ___yes ___no

If Yes, Name of Subscriber _____

Employer_____

Insurance Co._____

Ins. Claim Address_____

Ins. Co. Phone #_____Policy #_____
