GUARANTOR INFORMATION: (List person or insured name responsible for bill – use full legal name, no nicknames)

Relationship of Guarantor to Patient: Self____ Spouse____ Parent____ Other____

Last Name, First: _____ Social Security #_____

Street Address: _____ _____ Zip Code _____

* Employer Name: _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE

Plan Name: _____ * Insured's Name: ___ _____

Insured's Social Security #: _____ * Insured's Date of Birth: _____

* Policy / ID #: _____ * Group #: _____ * Eff Date: _____

Claims Address & Phone: _____

SECONDARY INSURANCE

Plan Name: _____ * Insured's Name: _____

* Insured's Social Security #: _____ * Insured's Date of Birth: _____

* Policy / ID #: _____ * Group #: _____ * Eff Date: _____

Claims Address & Phone: _____

*** REQUIRED FILEDS – PLEASE COMPLETE FOR BILLING ***

*** ATTACH COPY OF INSURANCE CARDS ***