INSURANCE INFORMATION

Responsible Party (if someone other than patient)

Name____ Party is: Primary Ins holder, Secondary Ins holder, Other

Address:____City________________________State______ Zip_________

Phone: (HM)______________________(WK)____________________(CELL)________________Birth date________________

Policy Holder Information

Primary:

Name of Insured ____________________________________Relation to Patient_________________

Insured SS#_________________________ Birth date________________

Employer: ______________________Address: ________________City: ______________ST/Zip: ____/_____

Insurance Co.:______________________________ Policy #:______________ &/or Group#:______________

Claim Address:________________________ City: _________________________ ST/ Zip: _____/_________

Secondary:

Name of Insured ____________________________________Relation to Patient_________________

Insured SS#_________________________ Birth date________________

Employer: ______________________Address: ________________City: ______________ST/Zip: ____/_____

Insurance Co.:______________________________ Policy #:______________ &/ or Group#:_____________

Claim Address:________________________ City: _________________________ ST/ Zip: _____/_________

RELEASE

I have reviewed the information on both sides. I authorize the release of any information concerning my (or my child's) healthcare for the purpose of the evaluation and administering of claims for insurance benefits. I hereby authorize payment directly to Dr. Rothrock for the group benefits otherwise directly payable to me. I certify to the best of my knowledge that all information front and back is correct and that if there are any changes in the information, I agree to notify this office on or before my next visit.

Signature____ Date______________________________