Patient's Insurance Information

Patient's Name ______________________________

Birth Date ______________________________

Relationship to Insured __________________________

Insured Name ______________________________

Birth Date ______________________________

Social Security or Member ID Number _________________

Employer ______________________________

Employer address ______________________________

Insurance Name ______________________________

Policy or Group Number ______________________________

Insurance Number ______________________________

Insurance Mailing Address __________________________

I hereby authorize the release of any information including the diagnosis and the records of any treatment or examination rendered, to my insurance company(s). The release is solely for the purpose of facilitating the billing and reimbursement directly to the doctor of insurance benefits under which I am entitled.

Signature____

Date:_____________ Print Name:___________________________