



INSURANCE INFORMATION:

Your insurance card may have been scanned, however, in order to process your claim correctly, we need to have complete and accurate information. Please complete the section(s) below.

1- PRIMARY Insurance Company Name _____

Insurance ID# _____ Policy/Group # _____

Co Pay Amount:\$ _____ Medical Claims address _____

Subscriber Information: *PLEASE complete unless the patient is the subscriber.*

Name of person to whom the policy is issued _____ Relationship to Patient _____

Date of Birth _____ Social Security Number _____ Telephone # _____

Mailing Address(if different than patient's) _____
PO Box or Street City State Zip

Name of Employer (if issued through employment) _____

2-SECONDARY Insurance Company Name _____

Insurance ID# _____ Policy/Group # _____

Co Pay Amount:\$ _____ Medical Claims address _____

Subscriber Information: *PLEASE complete unless the patient is the subscriber or same as above.*

Name of person to whom the policy is issued _____ Relationship to Patient _____

Date of Birth _____ Social Security Number _____ Telephone # _____

Mailing Address(if different than patient's) _____
PO Box or Street City State Zip

Name of Employer (if issued through employment) _____

APPOINTMENT INFORMATION (must be completed for insurance purposes):

Where did the injury happen (location) _____

Date which problem started **OR** date of injury _____ **Body part** **Right** **OR** **Left**

Please check one of the following: Shoulder Arm Hand Wrist Leg Knee Clavicle
 Back Spine Neck Hip Foot Ankle Finger Toe Other _____