Insurance Information

(Primary Insurance)
Name of Insurance Company: ______________________________
Address: ______________________________
City: ____________________ State: __________ Zip: __________
Policy ID/Account Number: ____________________ Group Number: ____________________
Insured's Name: ____________________ Insured's DOB: ____________________
Relationship to Patient: ______________________________

(Secondary Insurance)
Name of Insurance Company: ______________________________
Address: ______________________________
City: ____________________ State: __________ Zip: __________
Policy ID/Account Number: ____________________ Group Number: ____________________
Insured's Name: ____________________ Insured's DOB: ____________________
Relationship to Patient: ______________________________

Is your visit today work related? ☐ Yes ☐ No If yes, what is the date of injury? __________
If your visit today due to an Auto Accident? ☐ Yes ☐ No
Have any X-rays been taken with regards to today's visit? ☐ Yes ☐ No Location: __________

Standard Authorization of Use and Disclosure of Protected Health Information

- The information covered in this authorization form includes medical mail outs, lab test results, diagnostic testing results, pertinent medical information and account status.
- You have the right to request restriction of use and disclosure of your health information for any purpose than those listed. Any changes to this information must be submitted in writing to this office.
- Information Disclosed under this authorization may be disclosed again by the person or organization to which it is sent. Once we disclose this information to another party, it becomes their responsibility to protect your right of privacy.

How would you like to be contacted regarding treatment, test results, pertinent health care information or the status of your account? Mail __________ Home Phone __________ Cell Phone __________

May we leave a message regarding treatment, test results or status of your account? ☐ Yes ☐ No
If no, how may we contact you regarding this information? ____________________
Please list any specific restrictions regarding your medical information. ____________________

Please specify any person(s) or organization(s) with Whom Information may be Disclosed:

____

Patient/Representative Signature: ____________________ Date: __________