

**DEPENDENT / PATIENT INSURANCE INFORMATION:**

Date: \_\_\_\_\_

Patient: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

Responsible Party (Parent/Guardian): \_\_\_\_\_ SSN: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_ Driver's License: \_\_\_\_\_

Address: \_\_\_\_\_

**Primary Insurance Information:**

Name of Insured: \_\_\_\_\_ SSN or Insurance ID: \_\_\_\_\_

Birth Date of Insured (mm/dd/yyyy): \_\_\_\_\_

Employer (Group) Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

**Secondary Insurance Information:**

Name of Insured: \_\_\_\_\_ SSN or Insurance ID: \_\_\_\_\_

Birth Date of Insured (mm/dd/yyyy): \_\_\_\_\_

Employer (Group) Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_