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:_____