



**Complete a health insurance section for each of your health plans/coverages.**

**PRIMARY INSURANCE:**

Subscriber		
Subscriber Name: _____	Date of Birth: _____	
Name of Health Insurance Company: _____		
ID/Policy Number: _____	Group Number: _____	Effective Date of Policy: _____
Patient Relationship To Subscriber: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARTNER <input type="checkbox"/> DEPENDANT		
Is the Insurance through Subscriber's Current Employer YES: <input type="checkbox"/> NO: <input type="checkbox"/>		
IF YES, EMPLOYER NAME: _____		
Does patient have additional health insurance?		
<input type="checkbox"/> YES. If yes, please complete corresponding sections, sign, print name and date.		
<input type="checkbox"/> NO. If no, please sign, print name and date.		

**SECONDARY INSURANCE:**

Subscriber		
Subscriber Name: _____	Date of Birth: _____	
Name of Health Insurance Company: _____		
ID/Policy Number: _____	Group Number: _____	Effective Date of Policy: _____
Patient Relationship To Subscriber: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARTNER <input type="checkbox"/> DEPENDANT		
Is the Insurance through Subscriber's Current Employer YES: <input type="checkbox"/> NO: <input type="checkbox"/>		
IF YES, EMPLOYER NAME: _____		
Does patient have additional health insurance?		
<input type="checkbox"/> YES. If yes, please complete corresponding sections, sign, print name and date.		
<input type="checkbox"/> NO. If no, please sign, print name and date.		

**TERTIARY INSURANCE:**

Subscriber		
Subscriber Name: _____	Date of Birth: _____	
Name of Health Insurance Company: _____		
ID/Policy Number: _____	Group Number: _____	Effective Date of Policy: _____
Patient Relationship To Subscriber: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARTNER <input type="checkbox"/> DEPENDANT		
Is the Insurance through Subscriber's Current Employer YES: <input type="checkbox"/> NO: <input type="checkbox"/>		
IF YES, EMPLOYER NAME: _____		
Does patient have additional health insurance?		
<input type="checkbox"/> YES. If yes, please complete corresponding sections, sign, print name and date.		
<input type="checkbox"/> NO. If no, please sign, print name and date.		

**Patient/Parent/Legal Guardian (signature):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **M:** \_\_\_\_\_ **F:** \_\_\_\_\_ **Patient/Parent/Legal Guardian (print name):** \_\_\_\_\_