



Patient

Dob

Address

Phone Number

Primary:

Insurance Carrier:

Identification Number:

Group Number:

Assigned Provider if Applicable:

Policy Holder:

Policy Holder DOB:

Policy Holder Sex:

Policy Holder Employer:

Secondary:

Insurance Carrier:

Identification Number:

Group Number:

Assigned Provider if Applicable:

Policy Holder:

Policy Holder DOB:

Policy Holder Sex:

Policy Holder Employer:

I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments.

Parent Signature

Date