PATIENT INSURANCE INFORMATION

Patient Name: _____

Date of Birth: _____ **Social Security #**_____

Primary Insurance:

Company Name:_____

Address:_____

Telephone: _____

ID# _____ **Group#** _____

Policy Holder Name (if different from Patient): _____

Relationship of policy Holder to Patient: _____

Prescription Drug Policy: **( ) Provides up to 30 days at a time**
( ) Provides up to 90 days at a time
( ) No prescription drug coverage

( ) Mail away option for 90 days (please provide information):

_____

_____

_____

_____

( ) Other:

_____

_____

_____

Secondary Insurance:

Company Name:_____

Address:_____

Telephone: _____

ID#_____ **Group#** _____

Policy Holder Name (if different from Patient): _____

Relationship to patient: _____