INSURANCE INFORMATION CHART #: _____

Patient Name: _____ Appt. Date: _____
first middle last

PRIMARY INSURANCE

Name of Company: _____

Address of Company: _____

City: _____ State: _____ Zip Code: _____

Insured's Name: _____

Group #: _____ Policy ID #: _____

Effective Date of Coverage: _____

Complete this section only if cardholder's information has not been given.

Cardholder: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: ( ) _____ Birth date: _____ Age: _____

Occupation: _____ Social Security #: _____

Employer: _____ Length of Employment: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

SECONDARY INSURANCE

Name of Company: _____

Address of Company: _____

City: _____ State: _____ Zip Code: _____

Insured's Name: _____

Group #: _____ Policy ID #: _____

Effective Date of Coverage: _____

Complete this section only if cardholder's information has not been given.

Cardholder: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: ( ) _____ Birth date: _____ Age: _____

Occupation: _____ Social Security #: _____

Employer: _____ Length of Employment: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

Signature of Patient or Legal Guardian: _____ Date: _____

I authorize the release of any medical information necessary to process this claim

Signed: _____ Date _____
insured or authorized person

I authorize payment of medical and surgical benefits to Valley ENT, Allergy, and Cosmetic Surgery

Signed: _____ Date _____
insured or authorized person