

# 2017 INSURANCE UPDATE

Patients Name: \_\_\_\_\_ DOB: \_\_\_\_\_

\*\*\*Name of Primary Insurance Co: \_\_\_\_\_

Policy holder's Insurance ID #: \_\_\_\_\_ Group # \_\_\_\_\_

Policy holder's DOB: \_\_\_\_\_ Policy holder: \_\_\_\_\_

Effective date of policy: \_\_\_\_\_ Employer: \_\_\_\_\_

**SCANNED: YES or NO**

\*\*\*Name of Secondary Insurance Co: \_\_\_\_\_

Policy holder's Insurance ID #: \_\_\_\_\_ Group # \_\_\_\_\_

Policy holder's DOB: \_\_\_\_\_ Policy holder: \_\_\_\_\_

Effective date of policy: \_\_\_\_\_ Employer: \_\_\_\_\_

**SCANNED: YES or NO**

**Parents' Status: Married Separated Divorced Single Widowed Partner**

1<sup>st</sup> Guardian's Name/address: \_\_\_\_\_  
Name/address City State Zip

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

2<sup>nd</sup> Guardian's Name/address: \_\_\_\_\_  
Name/address City State Zip

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Child / Children's Primary residence: \_\_\_\_\_  
City State Zip

Family's Email Address \_\_\_\_\_

**Names of siblings and under which policy they are covered.**

\_\_\_\_\_ DOB \_\_\_\_\_ Primary / Secondary or Both

\_\_\_\_\_ DOB \_\_\_\_\_ Primary / Secondary or Both

\_\_\_\_\_ DOB \_\_\_\_\_ Primary / Secondary or Both

\_\_\_\_\_ DOB \_\_\_\_\_ Primary / Secondary or Both

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TO SUBMIT CLAIMS CORRECTLY, WE NEED TO SCAN ALL YOUR CHILDREN'S INSURANCE CARDS.