# PATIENT BILLING INFORMATION

**PATIENT INFORMATION**

Name: _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
Employer: _____ Work Address: _____
Referred By: _____ Primary Doctor: _____
Spouse's Name: _____
Spouse's Employer: _____ Address: _____

**IF PATIENT IS A MINOR PLEASE PROVIDE THE FOLLOWING INFORMATION**

Mother's Name: _____ Father's Name: _____
Mother's Work Phone: _____ Father's Work Phone: _____
Mother's Cell: _____ Father's Cell: _____
Mother's Employer: _____ Father's Employer: _____

**PRIMARY INSURANCE INFORMATION**

Primary Insurance Company: _____
Insurance ID Number: _____ Insurance Group Number: _____
Address: _____ City: _____ State: _____
Insured's Name: _____ Insured's DOB: _____
Insured's Address: _____ City: _____ State: _____
Insured's Employer: _____
Employer's Address: _____City: _____ State: _____

**SECONDARY INSURANCE INFORMATION**

Secondary Insurance Company: _____
Insurance ID Number: _____ Insurance Group Number: _____
Address: _____ City: _____ State: _____
Insured's Name: _____ Insured's DOB: _____
Insured's Address: _____ City: _____ State: _____
Insured's Employer: _____
Employer's Address: _____City: _____ State: _____

***When submitting this form, please attach a copy of the front and back of your insurance card(s).***

If your insurance company fails to pay all or part of the fee incurred, payment shall be the responsibility of the patient and/or the insured.

I hereby give permission for this office to release information to my insurance company or managed health care for the purpose of billing, treatment planning, utilization review or other requests. I also authorize payment to be made directly to the provider.

Signature: _____ Date: _____

Authorization Number: _____ Diagnosis Code: _____