Please bring completed form with you on October 1st

PATIENT INSURANCE INFORMATION FORM

ATTENTION: Please Print CLEARLY and complete ENTIRE form.

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: ________________________________ First Name: _____________________________ MI: ________

Address: _______________________________________ City: ___________________ State: _______ Zip: ________

Date of Birth: ______________________ Email: ____

Phone: (_______) _______________ Employer: ____

Sex: Male Female Marital Status: Married Single Other

Do you have Medicare? Yes No

Do you have Insurance through your Employer? Yes No

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name: ____

Member or Subscriber ID Number: ____________________________________ Group Number: ________________

PRIMARY INSURED / POLICY HOLDER INFORMATION

Full Name of Policy Holder: ____

Sex: Male Female DOB: ____________________________ Relationship to patient: ______________________

Address: _______________________________________ City: _________________ State: ______ Zip: ___________

Phone: (_______) _______________________ Employer: ____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name: ____

Policy or Subscriber ID # _______________________________________ Group # _______________________

SECONDARY POLICY HOLDER INFORMATION

Full Name of Policy Holder: ____

Sex: Male Female DOB: ____________________________ Relationship to patient: ______________________

Address: _______________________________________ City: _________________ State: ______ Zip: ___________

INSURANCE ASSIGNMENT AND FINANCIAL RESPONSIBILITY

I hereby authorize The Vaccination Clinic PC dba SHOTS, etc to release to my insurance company any medical or other information given to SHOTS, etc during the provision of services. I authorize payment to The Vaccination Clinic PC dba SHOTS, etc from my insurance for any benefits due for services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services. I understand that I am financially responsible for the portion of the fees not paid by my insurer. I understand that if my payment to SHOTS, etc is dishonored by my financial institution, I am responsible for those payments as well as any bank or legal expenses incurred in collecting these funds. I give permission for The Vaccination Clinic PC dba SHOTS, etc or anyone acting on their behalf to contact me via my cell phone number to collect any debt owed.

Signature of Patient: ____ Date: ___________________________