Billing and Insurance Update Form_____ Date:_____

Patient Information: Same_____ New_____

Patient Name_____

Street Address_____

Mailing Address(***if different from street address***)_____

City_____State_____Zip Code_____

Home Phone #_____Work Phone#_____

Billing Information: Same_____ New_____

Name of Responsible Party (***if other than self***)_____
Address_____City_____State_____Zip_____
Relationship_____Phone Number_____

Insurance Information: Same_____ New_____

Insurance Information ***(Please bring proof of insurance to your appointment or you will be responsible for full payment at time of service. This section must be filled out completely or we cannot process your claim.)***

Effective Date of Change in Insurance:_____
Have you called your insurance for an Authorization #? If so, what is the #_____
Previous Insurance:_____**Expiration Date:**_____

Patient's ID #: _____ Insurance Company: _____

Subscriber's SSN: _____ (***Subscriber is the person who holds the insurance policy***.)

Subscriber's Last Name: _____

Subscriber's First Name: _____ Middle Initial: _____

Patient Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other

Street Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Subscriber's Birth Date: _____ Subscriber's Employer:_____

I authorize the release of any medical information necessary to process this claim.
Signature_____***Date***_____

I authorize payment of medical benefits to my physician or supplier for services provided.
Signature_____***Date***_____

Please list all providers seen at this office_____