

Insurance Intake Form

Name _____ Today's Date ____/____/____
Last First MI

Mailing Address _____ Date of Birth ____/____/____

City State Zip email: _____

Phone (home) _____ (cell) _____
(Area code) Phone (Area code) Phone

Sex: Male Female Social Security #: _____ - _____ - _____

Employer: _____ Phone _____

Primary care physician _____ Phone _____

The following relates to your payment for health care services provided. Please complete the following section carefully, and let us know if you have any questions.

• Did this injury occur on the job? yes no If yes, date of injury: ____/____/____

Claim number: _____ Claims manager or contact person: _____

• Was this injury caused by a motor vehicle accident? yes no If yes, date of injury: ____/____/____

Claim number: _____ Claims manager or contact person: _____

• Please bill my insurance. I will provide you my insurance card to copy.

• Please bill me directly at the above address or an alternative address that I have provided.

I understand that I am financially responsible for all charges and agree to pay for services. I authorize the doctor to release to my insurance companies any and all information necessary to process my claims. I further authorize that payment be made directly to the physician.

Signature: _____ Date _____