

Patient and Insurance Information Form

Please take a moment to complete this form in its entirety, and sign at the bottom.
This will enable smooth insurance billing and reimbursement for our office. Thank you!

Patient Information

Name:	Date of Birth:	Gender: M F
Address:	Phone (home):	
State: Zip:	Phone (work):	
	Phone (cell):	
Employer:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Other	
Email:		

Primary or Medical Insurance

Plan Name:	ID # (include prefix):
Plan Address (back of card):	SS# (if different from ID#):
	Group #:
	Plan Phone# (back of card):

****Insured's Information, if other than self:** (do not skip this section!)**

Name:
Address:
Date of Birth:
Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other

PIP, L&I, or Secondary Insurance (complete this section if you have a work or auto injury)

Is your condition injury related?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, auto accident	<input type="checkbox"/> Yes, work related
Plan Name:	ID # or SS# (include prefix):		
Plan Address (back of card):	Claim #:		
	Adjuster:		
	Date of Injury:		
Name of Insured:	Plan Phone #:		

Plan / Coverage Details

Co Pay: \$	Orthotic coverage?	Yes	No	Limits:
Annual Deductible: \$	Co-insurance payment:			
Yearly Max for Prevention visits	Eligibility confirmed:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	\$	# of visits:		
COVERAGE LIMITS	\$ AMOUNT	# OF VISITS	REFERRAL OR PRESCRIPTION NEEDED?	
Naturopathic	\$	#	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Self Ref. OK
Physical Medicine	\$	#	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Self Ref. OK
Acupuncture	\$	#	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Self Ref. OK
Massage	\$	#	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Self Ref. OK
Have you gotten the needed referrals or prescriptions?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	I confirmed coverage with (name):

Referring Physician's Name: _____ Phone: _____

I agree to the release of any medical information my health insurance may need in order to process payment. I assign such benefits to be paid to _____. I understand that I am ultimately responsible for all fees incurred, (for instance, if my insurance coverage expires or denies payment). I take full responsibility for knowing my insurance coverage and limits, and will work toward the goal of helping my practitioner to be fully reimbursed for her services.

Signature _____ Date _____