

INSURANCE VERIFICATION

Name of Patient: _____ **DOB:** _____

Name of Insured: _____ **DOB:** _____
(person who carries insurance)

Home Phone: _____ **Cell Phone:** _____

Insured Place of Employment: _____ **Phone:** _____

Insurance Company: _____

Insurance I.D. Number: _____

Insured Social Security Number: _____

Effective Date: _____

Office Visit Copay amount: _____

Insurance Company phone#(customer service) _____

Appointment Date: _____ **Appointment Time:** _____

Arrival Time: _____ **Doctor seeing:** _____

Shot records: _____ **Medical Records:** _____

Fax# _____ **Atten:** _____

Custody records: _____

Previous Physician: _____

Reason for transferring to us: _____

Completed By: _____ **Date:** _____ **Time:** _____

Appointment cancelled: _____

Appointment rescheduled: _____