<u>INSURANCE VERIFICATION</u>

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:______________________________________