Insurance Information

Patient Name: ____ Date of Birth: _____________

Previous and/or Maiden Name(s): ____

Address: ____

City, State, Zip: ____

Primary Phone #: ______________________ Secondary Phone #:________________________

Social Security # or Driver License #: ____

Primary Insurance:
Insurance Company Name: ____

Claims Address: ____

City, State, Zip: ____

Insured's Name: ____

Policy #: ____________________________ Group/Plan #: ________________________________

Secondary Insurance:
Insurance Company Name: ____

Claims Address: ____

City, State, Zip: ____

Insured's Name: ____

Policy #: ____________________________ Group/Plan #: ________________________________

*If anything is sent to pathology (i.e. pap smear, biopsy, etc.), a copy of this form will go to the lab so that they can file your insurance. You will receive a separate bill from that facility for any balance that your insurance does not pay.