

Billing Information

Today's Date _____

Name _____ Date of Birth _____
Last First M.I.

Address _____
Street Apt. #
_____ City State Zip

Home Phone _____ OK to leave message? _____

Work Phone _____ OK to leave message? _____

Cell Phone _____ Email address _____

SSN _____ Referred by _____

Person responsible for bill _____

Address _____
Street Apt. #
_____ City State Zip

Employer _____

Address _____

Insurance Company _____

Address _____
_____ Phone _____

Client's Relationship to Insured _____

SSN of Insured _____ DOB of Insured _____

Have you met your deductible for the year? _____

Have you called to check co-payment amount and pre-authorization? _____

Group No. _____

Policy No. _____ I.D. No. _____

For Office Use Only

DX _____

Copy of Insurance Card Attached _____