INSURANCE PROFILE

Please Print

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Other	❑ Feca Blk Lung	❑ Medicare	❑ Medicaid	❑ Tricare Champus	❑ CHAMPVA	❑ Group Health Plan

Patient Status

☐ Single ☐ Married ☐ Other

☐ Employed ☐ Full-time Student ☐ Part-time Student

Is Patient's Condition Related To:

a. Employment? (Current or Previous)
☐ Yes ☐ No

b. Auto Accident?
☐ Yes ☐ No

c. Other Accident?
☐ Yes ☐ No

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Notes:

MINDFULL STRATEGIES