

INSURANCE INFORMATION (PLEASE PRINT)

Date: _____

1. PRIMARY INSURANCE:

Person Responsible for Account: _____
Last First MI

Date of Birth: _____ Social Security #: _____

Relation to Patient: _____ Home Phone: () _____

Address: _____ City: _____ Zip: _____

Person responsible Employed by: _____ Occupation: _____

Business Address: _____ City: _____ Zip: _____

Cell / Pager: () _____ Business Phone: () _____

Insurance Company: _____

Insurance ID #: _____ Group #: _____

Names of other dependants covered under this plan: _____

Is Patient Covered by Another Insurance? () Yes () No

2. ADDITIONAL OR SECONDARY INSURANCE:

Person Responsible for Account: _____
Last First MI

Date of Birth: _____ Social Security #: _____

Relation to Patient: _____ Home Phone: () _____

Address: _____ City: _____ Zip: _____

Person responsible Employed by: _____ Occupation: _____

Business Address: _____ City: _____ Zip: _____

Cell / Pager: () _____ Business Phone: () _____

Insurance Company: _____

Insurance ID #: _____ Group #: _____

Names of other dependants covered under this plan: _____

3. ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage, or I am paying cash, and assign directly to **AV Pediatrics, Allergy and Family Medicine** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that this office bills my insurance as a **courtesy** and that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this office or its agents to release any and all information necessary to secure the payment of benefits. I also authorize the release of any and all information requested by a laboratory, insurance company or legal counsel. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date