

## INSURANCE INFORMATION

DUE TO MANDATORY HEALTHCARE PRIVACY REGULATIONS, THE FOLLOWING INFORMATION IS REQUIRED IN ORDER FOR US TO FILE YOUR INSURANCE. IF NOT PROVIDED, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL AT TIME OF SERVICE.

NAME OF INSURANCE COMPANY: _____	
POLICY HOLDER NAME: _____	DATE OF BIRTH: _____
POLICY HOLDER SSN: _____	SEX: _____
POLICY HOLDER RELATIONSHIP TO PATIENT: _____	
NAME OF SECOND INSURANCE (IF APPLICABLE): _____	
POLICY HOLDER NAME: _____	DATE OF BIRTH: _____
POLICY HOLDER SSN: _____	SEX: _____
POLICY HOLDER RELATIONSHIP TO PATIENT: _____	
NAME OF THIRD INSURANCE (IF APPLICABLE): _____	
POLICY HOLDER NAME: _____	DATE OF BIRTH: _____
POLICY HOLDER SSN: _____	SEX: _____
POLICY HOLDER RELATIONSHIP TO PATIENT: _____	