INSURANCE FORM

Please fill in the insurance information you will be using.

PERSONAL HEALTH PLAN

Primary Insurance:_____ ID#_____ Group #_____

Secondary Insurance:_____ ID#_____ Group #_____

Patients that have been involved in a motor vehicle accident should be aware that it is state law to submit to your auto insurance if you have medical payments. If you do not, than a letter of no medical payment is needed before your primary insurance will pay. Any questions should be directed to your attorney, if applicable.

MOTOR VEHICLE INSURANCE

Carrier:_____ Address:_____ Phone #_____

Policy #_____ Medical Coverage?_____ Amount _____

WORKERS COMPENSATION

Carrrier:_____ Address:_____ Phone #_____

Person to Contact:_____ Claim #_____ Claim Being Contested? _____

ATTORNEY INFORMATION

Attorney Name:_____

Street:_____

City, State, and Zip Code:_____

Telephone Number: _____