INSURANCE & FINANCIAL INFORMATION

Patients Name: ______________________________ DOB: __________________ Date: ________________

Are you being seen for a work or auto accident injury? ☐ Yes ☐ No If yes, please ask for "Injury Form" ☐ Work ☐ Auto

Responsible Party

Name ____ SSN#_________________
Last First MI

☐ Mother ☐ Father ☐ Step Mother ☐Step Father ☐ Guardian (☐ M ☐ F) Date of Birth: ____-____-____

Billing Address: ____
Street Address & PO Box City State Zip

Home Phone #________________ Cell #_______________ E-mail address__________________________

Employer____
Name Address Work #

Primary Insurance

Policy Owner: ______________________________

Relationship to the patient: _____________________

Address: __________________________________

City: _________________ State: _____ Zip: ________

Home #: ______________ Cell #: ______________

SS#: _______________ Birthdates: ______________

Employer: __________________________________

Employer Address: ___________________________

City: _________________ State: _____ Zip: ________

Work #:___________________________Ext: ________

Insurance Company: __________________________

Insurance Company Address: ____________________

City: _________________ State: _____ Zip: ________

Group # & Name: ____________________________

ID #: _____________________________________

Effective Date: ______________________________

Secondary Insurance

Policy Owner: ______________________________

Relationship to the patient: _____________________

Address: __________________________________

City: _________________ State: _____ Zip: ________

Home #: ______________ Cell #: ______________

SS#: _______________ Birthdates: ______________

Employer: __________________________________

Employer Address: ___________________________

City: _________________ State: _____ Zip: ________

Work #:___________________________Ext: ________

Insurance Company: __________________________

Insurance Company Address: ____________________

City: _________________ State: _____ Zip: ________

Group # & Name: ____________________________

ID #: _____________________________________

Effective Date: ______________________________

AUTHORIZATION FOR PAYMENT

I hereby assign, to transfer and set over to Wilson Care, LLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy(s). I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. **I understand that I am financially responsible for all charges whether or not they are covered by my insurance.**

____ ________________________
Patient or Responsibly Party Signature Date