

Insurance Questionnaire

Today's Date: _____

Primary Insurance

Patient Name: _____ Date of Birth: _____

Type of Insurance: Medicare Group Tricare Other: _____

Insured's Name (if different): _____ Date of Birth: _____

Insured's Address (if different): _____

Insured's SSN: _____ Employer: _____ Relationship: _____

Insurance Company Name: _____

Policy Number: _____ Group No.: _____

Is the condition we are treating related to current or previous employment? Yes No

Is the condition we are treating related to an auto accident? Yes No

Is the condition we are treating related to any other type of accident? Yes No

Is there another health or benefit plan? Yes No If yes, please list below.

Secondary Insurance

Type of Insurance: Medicare Group Tricare Other: _____

Insured's Address (if different): _____

Insured's SSN: _____ Employer: _____

Insurance Company Name: _____

Policy Number: _____ Group No.: _____

PLEASE BE SURE TO GIVE THE RECEPTIONIST YOUR INSURANCE CARD.