# INSURANCE INFORMATION

Today's Date: _____

Insurance Company: _____

Employer Name: _____

Insurance Co. Tel #: _____

Insurance Co. Add: _____

_____

Group #: _____

Policy Holder's Name: _____

Date of Birth / SS #: _____ / _____

Patient's Name: _____

Patient's DOB / SS #: _____ / _____

Maximum per year: $_____ Used to date: $ _____

Deductible (individual): $_____ Has Met: $ _____

Preventative: _____% Basic: _____% Major: _____%

Previous: Exam: _____ Prophy: _____

FMS:_____

Secondary Insurance: _____