SPOUSE INSURANCE HOLDER ACKNOWLEDGEMENT

If the insurance is carried by your spouse or parent this form needs to be completed fully. If this information is not completed completely you can either reschedule your appointment until you have this information or you can pay in full for the visit and get reimbursed by your insurance. This information is needed by the insurance when we send your claims in if we do not have it we do not get paid.

Insurance Subscriber Information

Name:____ **DOB**:_____________ **SSN**: _________________________

Phone Number: _________________________________ **Cell Number**: ____

Physical Address:____

City:______________________________________ **State**:___________________ **Zip Code**:________________________

Mailing Address (if different):____

City:______________________________________ **State**:___________________ **Zip Code**:________________________

Relationship to Patient: ____

Subscribers Employment Information

Full Employer Name:____

Employer Full Address: ____

City:_______________________________________ **State**:______________________ **Zip Code**:____________________

Employer Phone Number: ____

If patient is Military this information above and below are needed.

Commanders Name:____
Commanders Phone Number: ____