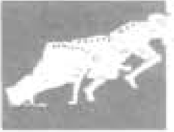

PATIENT INSURANCE FORM

Please PRINT

FIRST (PRIMARY) INSURANCE INFORMATION

Carrier Name	Insured's Name (as printed on card)	Insured's Employer Name
Social Security #	Insured's DOB	Relationship to Patient
Policy #	Group #	Effective Date

SECOND (SECONDARY) INSURANCE INFORMATION

Carrier Name	Insured's Name (as printed on card)	Insured's Employer Name
Social Security #	Insured's DOB	Relationship to Patient
Policy #	Group #	Effective Date

OTHER INSURANCE INFORMATION

Injury due to an accident: [ ] At Work [ ] Automobile Accident [ ] Other

Accident City	Accident State	Date of Accident
Insurance Company	Policy #	Claim #

ASSIGNMENT OF BENEFITS AND AUTHORITY TO RELEASE INFORMATION

I hereby authorize the above named insurance company to directly pay Santiago Chiropractic Associates all benefits due to me for services rendered as provided for in my insurance policy. Further, I authorize release of information deemed appropriate concerning my physical condition to any insurance company, attorney, adjuster, or other physicians.

Signature of Patient or Responsible Party

Date