## **Primary Insurance and/or Person Responsible for Payment**

Name First	MI	Last	
Relationship to patient_			
Street Address			
		Zip	
Telephone: Home	Work	Cell	
Social Security Number		Date of Birth	
Occupation			
Insurance Company		Telephone	
Group Number	C	Contract Number	
Spo	ouse and/or Secon	idary Insurance	
Name			
First	MI	Last	
Relationship to patient_			
Street Address			
		Zip	
Telephone: Home	Work	Cell	
Social Security Number		Date of Birth	
Occupation			
Insurance Company		Telephone	
Group Number	C	Contract Number	
provide insurance billing a	~	s correct. I realize that this office will enefits to the best of it's knowledge. esponsibility.	
Signature (Parent's if mir	nor)	Date	