



Billing Information

Patient's Information:

Patient's Last Name: _____ First: _____ M.I. _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: ____/____/____ Sex: _____ Race: _____
Home Phone: (____) _____ Work/Cell Phone: (____) _____
Employer's Name: _____ Employer's Phone: (____) _____

Financial Responsibility: (Person Financially Responsible for Patient Named Above)

Guarantor's Name: _____ Relationship to Patient: _____
Address: _____
City: _____ State: _____ Zip: _____
Signature: _____ Date: _____

Health Insurance (Primary):

Insurance Name and Address: _____

Policy # (ID#): _____ Group #: _____
Subscriber's Name: _____ Date of Birth: ____/____/____
Relationship to the Patient: _____ Pre-certification required: Y or N
Pre-certification #: _____

Health Insurance (Secondary):

Insurance Name and Address: _____

Policy # (ID#): _____ Group #: _____
Subscriber's Name: _____ Date of Birth: ____/____/____
Relationship to the Patient: _____ Pre-certification required: Y or N
Pre-certification #: _____