Insurance Verification and Referring Physician

-Please Print-

Date of Birth	Age	Gender at Birth	Gender Identity	Marital Status	Mobile Number

First Name	Middle Initial	Last Name	SSN or Last 4

Home Phone Number	E-Mail Address	Allow E-Mail Communications?
		Yes ____ No ____

Home Address	Apt #	City	State	County	ZIP Code

Work Phone & Extension	Employer Name	Employer's Address

Please provide the referring Doctor(s) information as well as your Primary Care Practitioner if applicable:

Dr. Name: _____ Dr. Name: _____

Address: _____ Address: _____

Telephone: _____ Telephone: _____

Fax(required):_____ Fax(required):_____

Would you like todays report forwarded to the above Doctor(s)? ____Yes ____No

Name of Escort: _____ **Phone Number**: _____

Did you bring a Health Care Proxy or Living Will to put on file? ____ Yes ____ No

1. Primary Insurance Name		Primary Insurance Address or Po Box	
Policy Number / Member ID		**Group Number**	
Policy Holder Name	**Date of Birth**	**Relationship**	**Social Security #**
2. Secondary Insurance Name		**Secondary Insurance Address or Po Box**	
Policy Number / Member ID		**Group**	
Policy Holder Name	**Date of Birth**	**Relationship**	**Social Security #**

Signature	Today's Date