

Parents: Please fill out insurance info below.

PATIENT EMPLOYER INFORMATION:

Patient's Employer: _____
Address: _____
Street address City/State Zip code
Job Title: _____ Work Phone: _____

GUARANTOR INFORMATION: The Guarantor is the person responsible for the bill.

Name: _____ Relationship: _____
Last name First name Middle Initial
Date of Birth: _____ Social Security Number: _____
Employer: _____
Employer's Address: _____
Street address City/State Zip code
Job Title: _____ Work Phone: _____
Home Address: _____ Home Phone: _____

INSURANCE INFORMATION: Please provide us with an insurance card so that we can make a copy.

Primary Insurance Holder: _____ Date of Birth: _____
Last name First name Middle Initial
Insurance Company Name: _____
Address: _____
PO Box/Street address City/State Zip code
Group Name (Employer): _____ Group Number: _____
Social Security Number: _____ ID Number: _____

Military Insurance Information:

Company: _____ Rank: _____
Effective Date: _____ Expiration Date: _____
Retired: Yes No

For Compensation Insurance:

Supervisor's Name: _____ Phone: _____

Secondary Insurance:

Insured's Name: _____
Last name First name Middle Initial
Insurance Company Name: _____
Address: _____
PO Box/Street address City/State Zip code
Group Name (Employer): _____ Group Number: _____
Insured's Social Security Number: _____ ID Number: _____

Please return this completed form, along with your insurance card, to the Urgent Care Nurse's Station.