Republic
Family Medicine llc
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Insurance Information
(If patient is not primary insured)

Patient's Name _____ **Birth date:** _____/_____/_____
Primary Insurance Subscriber: _____ **SSN:** _____
Birth date: _____/_____/_____ **Marital Status:** _____
Address : _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Cell Phone:** _____
Is this person a patient here? ( ) Y ( ) N Is this person covered by insurance? ( ) Y ( ) N
Occupation: _____ **Employer:** _____
Employer's Address: _____ **City:** _____ **State:** ___ **Zip:** _____

Primary Insurance: _____
Policy Number: _____ **Group Number:** _____ **Copay:** _____
Subscriber's name: _____ **Birth date:** _____/_____/_____
Patient's relationship to subscriber: _____

Secondary Insurance: (if applicable) _____
Policy Number: _____ **Group Number:** _____ **Copay:** _____
Subscriber's name: _____ **Birth date:** _____/_____/_____
Patient's relationship to subscriber: _____

Person responsible for bill (if different from primary subscriber):

Name: _____ **Birth date:** _____/_____/_____
Address (if different)**:** _____ **City:** _____ **State:** ___ **Zip:** _____
Is this person a patient here? ( ) Y ( ) N Is this person covered by insurance? ( ) Y ( ) N
Occupation: _____ **Employer:** _____
Employer's Address: _____ **City:** _____ **State:** ___ **Zip:** _____
Home Phone: _____ **Employer's Phone:** _____

The above information is true to the best of my knowledge.

Patient/Guardian Signature: _____ **Date:** _____/_____/_____

Relationship of Guardian: _____