SHERMAN COUNTY MEDICAL CLINIC

INSURANCE INFORMATION

Insurance Card and Photo ID are required at the time of registration**

Patient Name : _____ ***DOB :*** ____/____/____

Responsible Party: **This is the person responsible for any patient balances after insurance has been processed.**

Name: _____ Relationship to Patient: _____

_____ _____ _____

Mailing Address **City/State** **Zip code**

Contact number _____-_____-_____

PRIMARY INSURANCE **Subscriber Information*:*** *(If you are the subscriber you may write "SELF")*

*Insurance Company*_____

Name of subscriber: _____*DOB*___/___/_____*Relationship:*_____

Phone number: _____*Employer:*_____ *Work phone number:* _____

Insurance group number: _____*ID number:* _____*Effective date:* _____

SECONDARY INSURANCE **Subscriber Information*:*** *(If you are the subscriber you may write "SELF")*

*Insurance Company*_____

Name of subscriber: _____*DOB*___/__/_____*Relationship:*_____

Phone number: _____*Employer:*_____ *Work phone number:* _____

Insurance group number: _____*ID number:* _____*Effective date:* _____

*****By signing this page, you authorize Sherman County Medical Clinic to bill your insurance company/companies for medical claims. The responsible party is liable for payment of all charges not covered by the above listed insurance company/companies. ***All patient responsibilities should be paid within 90 days of billing statements to avoid this account being sent to collections.**

Signature: _____ ***Date:*** _____