

INSURANCE QUESTIONNAIRE

Nicole Holton, D.C.
923 NE Couch Portland, OR. 97232
(503) 236-9609

Please answer the following questions completely so that your insurance may be properly filed.
If information of INSURED is the same as PATIENT information, write "Same" on provided line.

Patient Name: _____ Insured's Name _____
(If same as patient write same)

Insured's Address: _____

Insured's Date of Birth: _____ Sex: Male _____ Female _____

Relationship to Insured: _____ Insured's Employer _____

Type of Insurance: Group _____ Other _____

Primary Insurance Plan Name: _____

Eligibility/Pre-certification Phone #: _____

Claims Address: _____

City: _____ State: _____ Zip: _____

Identification #: _____ Policy Group or FECA #: _____

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Secondary Insurance Plan Name (If applicable): _____

Eligibility/Pre-certification Phone #: _____

Claims Address: _____

City: _____ State: _____ Zip: _____

Identification #: _____ Policy Group or FECA #: _____

Patient's or authorized person's signature: I authorize the release of any information necessary (medical or other) to process my insurance claim. I also authorize payment of medical benefits to Nicole Holton, D.C. for the services described on the insurance form. This is to serve as long-term authorization and to apply for all occasions until it is revoked in writing.

Signed _____ Date _____