SOLID OAK ADULT AND PEDIATRIC CLINIC

INSURANCE INFORMATION (FORM MUST BE UPDATED YEARLY)

Patient Name: _____ **DOB:** _____

Please be sure to have your Insurance Card and Driver's License at your appointment as we will need copies for our records as well as proof of insurance is required at any visit. If complete insurance information cannot be provided at the time of service, the patient's appointment will need to be rescheduled. By not providing complete insurance information, as well as filling out this form completely, you are consenting to pay in full the cost treatment.

PLEASE FILL OUT THIS SECTION COMPLETELY, LEAVING IT BLANK WILL RESULT IN PATIENT RESPONSIBILITY

Primary Insurance Co. Name_____

Subscriber's Name (Policy Holder)_____

Relationship to Patient_____

Address of Subscriber_____

Phone Number of Subscriber: _____

Subscriber's Social Security # _____Date of Birth: _____

Contract or ID #_____ Group: _____

Insurance Address: _____

Secondary Insurance Co. Name_____

Subscriber's Name (Policy Holder)_____

Relationship to Patient: _____

Address of Subscriber_____

Phone Number of Subscriber: _____

Subscriber's Social Security # _____Date of Birth: _____

Contract or ID #_____ Group: _____

Insurance Address: _____

** IF THIS IS A GI PATIENT AND YOUR INSURANCE REQUIRS A REFERRAL, IT IS YOUR RESPONSIBILITY TO MAKE SURE WE HAVE IT ON FILE BEFORE YOUR VISIT. IF YOU AGREE TO SEE THE DOCTOR WITHOUT A REFERRAL, YOU ARE ACCEPTING RESPONSIBILITY FOR THE CHARGES**

GI Patient School Excuses:

_____ You must call the office the day the patient is absent. Only three excuses will be allowed between visits
Initial

Signature: _____ **Date:** _____

(Patient's signature is required if over the age of 14)