

HEARTLAND FAMILY FIRST MEDICAL CLINIC

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY: _____ CO-PAY: _____
GROUP #: _____ SUBSCRIBER #: _____
INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____
SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PHONE #: _____ EXT: _____
ADVANCED DIRECTIVE? YES NO WHERE IS IT FILED? _____ (what medical facility?)
INSURED EMPLOYED BY: _____ BUSINESS ADDRESS: _____
CITY: _____ STATE _____ ZIP: _____ BUSINESS PHONE #: _____

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? YES NO
INSURANCE COMPANY: _____ CO-PAY: _____
GROUP #: _____ SUBSCRIBER #: _____
INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____
SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PHONE #: _____ EXT: _____
INSURED EMPLOYED BY: _____
BUSINESS ADDRESS: _____ CITY: _____ STATE _____ ZIP: _____
BUSINESS PHONE #: _____

EMPLOYMENT STATUS: Employed Unemployed Full Time Student Part Time Student Retired
LAST DEGREE EARNED: HIGH SCHOOL COLLEGE GRADUATE SCHOOL
OCCUPATION: _____ BUSINESS NAME: _____
BUSINESS PHONE: _____

DRIVERS LICENSE #: _____ STATE ISSUED: _____

IS THIS AN ACCIDENT? YES NO DATE OF INJURY _____ IS THIS A MOTOR VEHICLE ACCIDENT?
 YES NO YES NO

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT
By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date: _____