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:*** ____________________