

INSURANCE INTAKE FORM

David Lerner, M.Ac., L.Ac.

Verify Benefits _____

PATIENT

Name _____

Address _____

Employer _____

PRIMARY PLAN INFORMATION

Plan Name _____

Address _____

RELATIONSHIP TO INSURED

Self _____ Child _____

Spouse ___ Other _____

SECONDARY INSURANCE INFORMATION

Plan Name _____

Address _____

Date of Birth _____

Phone (Home) _____

Phone (Work) _____

Single ___ Married _____

Male ___ Female _____

ID# _____

Group# _____

Phone# _____

INSURED INFORMATION, IF OTHER THAN YOURSELF

Name _____

Address _____

Date of Birth _____

ID# or Claim# _____

Adjuster's Name _____

Date of Injury _____

Name of Insured _____

I agree to the release of any medical information my health insurance may need in order to process payment. I assign some benefits to be paid to the above named provider. In the event that my insurance coverage expires or denies payment, I understand that I am personally responsible for all fees incurred unless other arrangements have been made.

Signature _____

Date _____