Patient Information

Name:_____
First Last Middle Initial
Address:_____
City:_____ **ST:**_____ **Zip Code:**_____
Sex: Male Female **Age:**_____ **DOB:**_____

Please list siblings seen in this office:

Primary Insurance

Responsible Party:_____
Last Name First Name Middle Initial
Relation to patient:_____ **Policy Holder DOB:**_____
Policy Holder ss#:_____ **Policy Holder Phone:**_____
Policy Holders Address:_____
City:_____ **St:**_____ **Zip Code:**_____
Insurance Company:_____ **Contract#:**_____

Additional Insurance

Is patient covered by additional health insurance? Yes or No
Subscriber Name:_____ **Relationship to patient:**_____
Policy Holder DOB:_____ **Address:**_____
City:_____ **ST:**_____ **Zip Code:**_____ **Phone:**_____
Insurance Company:_____ **Group:**_____
Contract#:_____ **Social Security :**_____

Assignment and Release

I, the undersigned certify that I(or my dependent) have insurance and assign directly to Dr.Robbins D.O. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

_____ _____ _____
Signature **Relationship** **Date**

Contact Information

Mothers Name:_____ **Email:**_____

Work#:_____ **Mobile#:**_____

Fathers Name:_____ **Mobile#:**_____