Insurance Verification Form

Welcome to our office. Please provide us with the information requested below so that we may assist you in filing your health insurance forms. All information will be kept confidential.

Patient's Name:_____ Date:_____

Sex: _____ Age:_____ Birth Date:_____ Soc. Sec. #:_____

Address:_____

City: _____ State: _____ Zip code: _____

Home phone:_____ Cell phone: _____

Email address:_____

Spouse's name (If child, Parent's name):_____

Name of insurance plan:_____

Group #:_____ Member ID#:_____

Insurance holder's name:_____ DOB:_____

Soc. Sec. #:_____ Relationship to insured:_____

Address:_____

City: _____ State: _____ Zip code: _____

Employer:_____ Occupation:_____

Address:_____

City: _____ State: _____ Zip code: _____

Reason for visit:_____

Race:_____ Ethnicity:_____ Primary language:_____

Emergency contact:_____ Phone#:_____

Internal Medicine Associates will bill the insurer of patient, however patient agrees to pay for the reasonable cost of all services provided and will be responsible and agrees to pay for any co-pay, deductible, or other charges not paid for by his insurance company

_____ _____

(Patient's Signature) **(Date)**