

---

---

**INSURANCE QUESTIONNAIRE**

Patient Name \_\_\_\_\_

The following questions are necessary so that we may properly file your insurance for you. Please answer as fully as possible.

**PRIMARY INSURANCE**

Type of insurance:  ASHP/ASN  Bluecross/Blueshield  Cigna  Kaiser  Medicare  PHCS  Other: \_\_\_\_\_

Insured's Name (as it appears on the insurance card): \_\_\_\_\_

Insured's Birth Date \_\_\_\_\_

Insured's ID # \_\_\_\_\_

Insured's Group # \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Insurance Plan \_\_\_\_\_

Patient is the:  Policy Holder  Spouse  Child

**SECONDARY INSURANCE**

Type of insurance:  None  AETNA  ARP  Bluecross/Blueshield  Cigna  United  Other: \_\_\_\_\_

Insured's Name (as it appears on the insurance card): \_\_\_\_\_

Insured's Birth Date \_\_\_\_\_

Insured's ID # \_\_\_\_\_

Insured's Group # \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Insurance Plan \_\_\_\_\_

Patient is the:  Policy Holder  Spouse  Child

Is there another Health Benefit Plan?  No  Yes: \_\_\_\_\_

**AUTO INSURANCE (for Personal Injury cases only)**

Type of insurance:  None  21<sup>st</sup> Century  AAA  All State  Farmers  Mercury  State Farm  Other: \_\_\_\_\_

Insured's Name \_\_\_\_\_

Policy/Claim Number \_\_\_\_\_

Patient is the:  Policy Holder  Spouse  Child  Other: \_\_\_\_\_

Adjuster's Name \_\_\_\_\_

Adjuster's Phone # \_\_\_\_\_

**THIRD PARTY INSURANCE (for Personal Injury cases only)**

Type of insurance:  None  21<sup>st</sup> Century  AAA  All State  Farmers  Mercury  State Farm  Other: \_\_\_\_\_

Insured's Name \_\_\_\_\_

Policy/Claim Number \_\_\_\_\_

Adjuster's Name \_\_\_\_\_

Adjuster's Phone # \_\_\_\_\_

Do you have an attorney representing you?  No  
 Yes: \_\_\_\_\_ Phone # \_\_\_\_\_

**WORKCOMP INSURANCE (for Work Compensation cases only)**

Who at your work authorized your visit to our office? \_\_\_\_\_ Phone # \_\_\_\_\_

I have not reported my accident to my employer yet

I have reported my accident to my employer but I do not have an authorization

I authorize the release of any medical or other information necessary to process my insurance claim. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_