Secondary Insurance

Complete either section A or B

A) My Family DOES NOT have a secondary insurance policy.

Parent or Guardian Name: ______________________________ Date: ________________

Parent or Guardian Signature: ______________________________

B) My Family DOES have a secondary insurance policy.

Patients covered by secondary policy:

Name: ______________________________________ DOB: _____/_____/_____ Sex: M or F

Name: ______________________________________ DOB: _____/_____/_____ Sex: M or F

Name: ______________________________________ DOB: ____/______/_____ Sex: M or F

Name: ______________________________________ DOB: ____/______/_____ Sex: M or F

Insurance Information:

Secondary Insurance: _________________________ Policy ID #: ______________________

Policy Holder Name_____________________________ DOB: _____/______/_____

Note: We will bill your secondary insurance one time. If payment is not received within 30 days the visit balance will be applied to your account.

Parent or Guardian Name: ______________________________ Date: ________________

Parent or Guardian Signature: ______________________________

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