Insurance Information

Patient Name_____Date_____

For **Medicare** patients only:

Medicare Number_____

I request that payment under the medical insurance program be made either to me or on my behalf to Dr. Bernfeld/Dr. Conroy/ Dr. Kisala/ Dr. Young for any services furnished to me by that physician and I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services.

Signature_____

For all other patients:

Primary Insurance

Insurance Name_____
Subscriber Name_____
ID Number_____Group Number_____
Employer_____DOB_____

Secondary Insurance

Insurance Name_____
Subscriber Name_____
ID Number_____Group Number_____
Employer_____DOB_____