

D'Agostino Chiropractic & Associates, PC

INSURANCE INFORMATION

Patient's Name _____ Social Security # _____

Address _____

City _____ State _____ Zip _____ Phone (____) _____

Name of Insured _____ Social Security # _____

Insurance Company _____

Address _____ City _____ State _____ Zip _____

Phone (____) _____

Type: Group Private Work/Comp Auto Accident

Policy # _____ Group # _____ Membership # _____ Cert. # _____

Employee # _____ Medicare # _____

For W/C only:

Employer _____ Supervisor _____

Address _____ City _____ Phone _____

Date _____ Time _____ Verified by: _____

Personnel/Supervisor

Staff Member: _____

For office use only:

Chiro. Cov? Yes No Deductible amount? \$ _____ How much met? \$ _____

Coverage for x-rays _____ % Office visits _____ %

Physical Therapy _____ % Supports _____ %

Any Chiropractic limitations, such as number of office visits, etc.? _____

Special Instructions or Additional Remarks: _____

Verified by _____ Completed by _____

Date _____

MAKE COPY OF PATIENT'S INSURANCE CARD. KEEP ALL INSURANCE CORRESPONDENCE/DOCUMENTS IN THIS FILE.