Patient Insurance Verification and Demographic Document

Please complete all sections below for medical record-keeping and insurance billing verification.

1. Patient Demographics

First Name:		Middle Initial:		Last Name:	
Date of Birth:	MM/DD/YYYY	Gender:		Social Security Number:	
Phone Number:		Email Address:			
Street Address:					
City:		State:		Zip Code:	

2. Primary Insurance Details

Insurance Company:		Policy ID / Member ID:	
Group Number:		Subscriber Name:	
Subscriber DOB:	MM/DD/YYYY	Relationship to Patient:	

3. Secondary Insurance Details (If Applicable)

Insurance Company:		Policy ID / Member ID:	
Group Number:		Subscriber Name:	
Subscriber DOB:	MM/DD/YYYY	Relationship to Patient:	

4. Insurance Verification (Office Use Only)

Verification Date:	MM/DD/YYYY	Verified By (Staff Name):	
Eligibility Status:	Active / Inactive	Copay Amount:	
Individual Deductible:		Deductible Met:	
Prior Authorization Required:	Yes / No	Reference / Call Number:	
Verification Notes:			