

**Billing and Insurance Update Form**

**Date:** \_\_\_\_\_

**Patient Information:** Same \_\_\_\_\_ New \_\_\_\_\_

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

Street Address \_\_\_\_\_

Mailing Address (*if different from street address*) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone# \_\_\_\_\_

**Billing Information:** Same \_\_\_\_\_ New \_\_\_\_\_

Name of Responsible Party (*if other than self*) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

**Insurance Information:** Same \_\_\_\_\_ New \_\_\_\_\_

**Insurance Information** *(Please bring proof of insurance to your appointment or you will be responsible for full payment at time of service. This section must be filled out completely or we cannot process your claim.)*

**Effective Date of Change in Insurance:** \_\_\_\_\_

Have you called your insurance for an Authorization #? If so, what is the # \_\_\_\_\_

**Previous Insurance:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_

Patient's ID #: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Subscriber's SSN: \_\_\_\_\_ (*Subscriber is the person who holds the insurance policy.*)

Subscriber's Last Name: \_\_\_\_\_

Subscriber's First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Relationship to Subscriber:  Self  Spouse  Child  Other

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Subscriber's Birth Date: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_

***I authorize the release of any medical information necessary to process this claim.***

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

***I authorize payment of medical benefits to my physician or supplier for services provided.***

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

***Please list all providers seen at this office*** \_\_\_\_\_