PATIENT INSURANCE INFORMATION FORM

PATIENT'S INFORMATION **FSAC #:** _____ (For Office Use Only) **TC SURGERY CENTER #:** _____ (For Office Use Only)

FIRST NAME: _____ **MI:** _____ **LAST:** _____

PRIMARY INSURANCE COMPANY

INSURANCE COMPANY: _____ **PHONE:** _____ **NAME OF INSURED:** _____

INSURANCE ADDRESS: _____ **BIRTH DATE:** _____

RELATIONSHIP TO PATIENT: _____

INSURED'S EMPLOYER: _____

CERTIFICATE / ID NUMBER: _____ **GROUP / POLICY #:** _____

SECONDARY INSURANCE COMPANY

INSURANCE COMPANY: _____ **PHONE:** _____ **NAME OF INSURED:** _____

INSURANCE ADDRESS: _____ **BIRTH DATE:** _____

RELATIONSHIP TO PATIENT: _____

INSURED'S EMPLOYER: _____

CERTIFICATE / ID NUMBER: _____ **GROUP / POLICY #:** _____

PARTNER'S INFORMATION

If different from above

FSAC #: _____ (For Office Use Only) **TC SURGERY CENTER #:** _____ (For Office Use Only)

FIRST NAME: _____ **MI:** _____ **LAST:** _____

PRIMARY INSURANCE COMPANY

INSURANCE COMPANY: _____ **PHONE:** _____ **NAME OF INSURED:** _____

INSURANCE ADDRESS: _____ **BIRTH DATE:** _____

RELATIONSHIP TO PATIENT: _____

INSURED'S EMPLOYER: _____

CERTIFICATE / ID NUMBER: _____ **GROUP / POLICY #:** _____

SECONDARY INSURANCE COMPANY

INSURANCE COMPANY: _____ **PHONE:** _____ **NAME OF INSURED:** _____

INSURANCE ADDRESS: _____ **BIRTH DATE:** _____

RELATIONSHIP TO PATIENT: _____

INSURED'S EMPLOYER: _____

CERTIFICATE / ID NUMBER: _____ **GROUP / POLICY #:** _____