Insurance Information

DiscoveryHealth

Patient's Full Name ______________________________

Date of Birth (mm/dd/yyyy) ______/______/__________

☐ This person is under 18 years of age.

Parent or Guardian Name:		
Address:		
Phone:		
This person is covered by the following insurance (check all that apply).	☐ Primary Insurance ☐ Additional / Supplemental Insurance	☐ Primary Insurance ☐ Additional / Supplemental Insurance

Primary insurance holder: ______________________________

Primary insurance provider: ______________________________

Policy number: ______________________________

Group or membership number: ______________________________

Provider phone number: ______________________________

Additional insurance holder: ______________________________

Additional insurance provider: ______________________________

Policy number: ______________________________

Group or membership number: ______________________________

Provider phone number: ______________________________

Use additional copies of this page to include all insurance coverage.