INSURANCE INFORMATION FORM

Developing Strong Futures
Orchard Place

FOR PERSON RECEIVING SERVICES

Last Name: _____ First Name: _____

Date of Birth: _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name: _____

Claims Mailing Address: _____

Phone Number of Insurance Co: _____

Policyholder Name: _____

Policyholder Address: _____

Policyholder Phone Number: _____ Policyholder DOB: _____

Gender: ○ Female ○ Male Relationship to Patient: _____

Policyholder Employer or School Name: _____

Policyholder ID# or SSN# (include alpha prefix if applicable): _____

Group Name & Number: _____ Plan: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name: _____

Claims Mailing Address: _____

Phone Number of Insurance Co: _____

Policyholder Name: _____

Policyholder Address: _____

Policyholder Phone Number: _____ Policyholder DOB: _____

Gender: ○ Female ○ Male Relationship to Patient: _____

Policyholder Employer or School Name: _____

Policyholder ID# or SSN# (include alpha prefix if applicable): _____

Group Name & Number: _____ Plan: _____

TERTIARY INSURANCE INFORMATION

Tertiary Insurance Company Name: _____

Claims Mailing Address: _____

Phone Number of Insurance Co: _____

Policyholder Name: _____

Policyholder Address: _____

Policyholder Phone Number: _____ Policyholder DOB: _____

Gender: ○ Female ○ Male Relationship to Patient: _____

Policyholder Employer or School Name: _____

Policyholder ID# or SSN# (include alpha prefix if applicable): _____

Group Name & Number: _____ Plan: _____

CAMPUS CLIENTS ONLY

Name of Dental Insurance: _____

Please provide a copy of your insurance card for our records.