Today's Date:_____/_____/_____

Patient Insurance Update Form

Patient Information

First Name:_____M.I.:_____Last Name: _____

Date of Birth:_____/_____/_____Social Security # (If pt is self responsible) ----------_____

Primary Insurance Update

Primary Insurance Company:_____Phone #: _____

Subscriber Name:_____D.O.B.:_____/_____/_____

SSN/ID#:_____Group #:_____Employer: _____

Claims Mailing Address: _____

Relationship to Patient: (Circle One) Self/Spouse-Partner/Parent/Guardian/Other

Secondary Insurance Update/Addition
(If Applicable)

Secondary Insurance Company:_____Phone #: _____

Subscriber Name:_____D.O.B.:_____/_____/_____

SSN/ID#:_____Group #:_____Employer:_____

Claims Mailing Address: _____

Relationship to Patient: (Circle One) Self/Spouse-Partner/Parent/Guardian/Other

Please provide us with your current insurance card. This will help us file for insurance reimbursement on your behalf. If you DO NOT provide us with accurate insurance information in a timely manner, you might be responsible for the charges.

In the event that timely payment cannot be made, special and specific arrangements may be made by calling our billing department at 661-588-40001 extension 308 or 322. We will be most understanding and willing to accommodate unusual circumstances.

Please E-mail, Fax, or Mail this sheet to us **prior** to your next appointment.

Email: bhinderbilling@yahoo.com

Fax: (661) 588-4042

Mailing Address: 6001 Truxtun Ave,Bldg A,Ste160
Bakersfield,CA 93309