Date: **Insurance Information** Dx:

Pt.'s Name:_____ Birthdate: _____

Mailing Address:
_____
_____
_____

Telephone #'s:
_____ Daytime: Work/Home
_____ Evening: Work/Home
May we leave a message? Y N

Name of Insurance Company: _____

Address of Insurance Company: _____
_____
_____

Telephone #'s of Insurance Company: _____

Certificate or Policy #: _____ Group #: _____
Employer's Name: _____

Pt.'s Social Security Number: _____Authorization #:_____

Subscriber's Name(If different from above): _____

Subscriber's Address (If different from above): _____

Subscriber's Birthdate (If different from above):_____

Subscriber's Social Security Number(If different from above)_____

Name of Secondary Insurance:* _____Policy :_____

*We do not bill secondary insurance companies but need the name for billing primary insurance.

Payment Authorization:

I authorize my insurance plan to pay benefits on my behalf to :
Dr. Catherine Cauthorne _____ Date: _____
Name of Adult Patient or Subscriber
I authorize Dr. Cauthorne to release information about my claims to my insurance company.
_____ Date: _____
Name of Adult Patient or Subscriber