

# CARING FAMILY, S.C.

PLEASE PRINT LEGIBLY

Complete entire form

Please note: We do not file claims with auto insurance companies

Today's date \_\_\_\_\_

**Patient information:** \_\_\_\_\_ Male \_\_\_\_\_ Female

Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_ Apartment number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_ Social Security number \_\_\_\_\_

\_\_\_MARRIED \_\_\_DIVORCED \_\_\_SINGLE \_\_\_WIDOWED \_\_\_MINOR

**Policy holder information:** \_\_\_\_\_ Male \_\_\_\_\_ Female

Policy holder name \_\_\_\_\_ Date of birth \_\_\_\_\_

Employer \_\_\_\_\_ City \_\_\_\_\_

Insurance company \_\_\_\_\_ ID number \_\_\_\_\_

Group number \_\_\_\_\_ Social Security number \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Copay \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**\*\*\*CARING FAMILY SUBMITS TO PRIMARY INSURANCE ONLY\*\*\***

BELOW IS FOR MEDICARE PATIENTS ONLY

Medicare Supplement name \_\_\_\_\_

Policy holder name \_\_\_\_\_

Date of birth \_\_\_\_\_ Social Security number \_\_\_\_\_