**RETURNING PATIENT BILLING INFORMATION**

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| --- | --- |
| **Patient Name** | **Guarantor’s (Policy Holder’s) Date of Birth** |
| **Date of Birth (Patient)** | Address |
| Home Phone | Work Phone |
| Mobile/Cell Phone  | Email Address |
| Patient Employer (or School Name if minor) | Occupation (if applicable) |
| Primary/Auto Insurance PolicyHealth Insurance Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Guarantor name and DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_Enrollee Id\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_ | Secondary/Auto Insurance Policy (if applicable)Health Insurance Plan \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Guarantor name and DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_Enrollee Id\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| We must have your health insurance on file, even if you have auto insuranceIf you have an auto claim has your claim number changed or updated? Do you have an attorney who is working with you? Please provide name and address |
| Primary Care/Referring PHYSICIAN NAME, ADDRESS, PHONE, FAX- Please provide  |
| Other specialists or treatment provider information |