**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 Policy  Health 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 insurance  If 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 | |