

## TO VERIFY INSURANCE

Patient Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Patient 's Employer: \_\_\_\_\_

S.S. #: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Spouse Name: \_\_\_\_\_

\*D.O.B.: \_\_\_\_\_

\*Spouse's Employer: \_\_\_\_\_

\*Spouse's D.O. B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*This information is needed if the Insurance card you are providing for your care has your spouse's name as the carrier.

Thank You for your cooperation.