INSURANCE INFORMATION

PLEASE PRINT
Insurance Information

Primary Health Plan name:	Policy #:	Effective Date:	
Name of Insured:		Relationship to Patient:	
Other Insurance? Y / N. If Yes, please state Name:		Policy #:	
Effective Date:	Name of Insured:	Relationship to Insured:	
Social Security Number:			
Have any of your Family members been seen in our office before? Y / N. If Yes please state name:			
Spouse's Name:		Telephone Number:	
Spouse's Employer:	Occupation:	Tel#: Cell#:	
Spouse's Social Security #:		DOB: (Tricare PTS Only)	
Nearest Friend or Relative Not Living at Home:		Telephone:	
Address:	City:	State:	Zip Code:
Emergency Contact:		Tel #:	
Address:	City:	State:	Zip Code:

Please present this form, your Driver's license and all insurance ID cards to the receptionist at the time of your visit. Please read the following authorization and sign the form where indicated.

I hereby consent to treatment provided by Dr. O. Bankole, I understand that I am responsible for all charges incurred whether or not paid by the above insurance company. I hereby authorize this office to release any and all information necessary to secure reimbursement from any insurance company to which I have subscribed. I herby authorize and direct payment to Dr. O. Bankole for the medical and/or surgical benefits if any, otherwise payable to me under the terms of my insurance. I agree and understand that I may be charged 1.5% interest rate per month on any unpaid balance and that I am responsible for any costs incurred in collection of said balance should that become necessary. I have read and understand the above and agree to comply.

Patient Signature_____ Date_____

Doctor's Signature_____ Date_____