Classic Practice Resources, Inc.

Insurance Information

Insurance Holder's Name   Sex   Birthday   Soc. Sec. #

____

Spouse's Name   Sex   Birthday   Soc. Sec. #

____

Dependent's Name (last name if different than yours)   Sex   Birthday

1. ____
2. ____
3. ____
4. ____

Insurance Holder's Employment ____

Insurance Company Name   Address   City   State   Zip

____

Any numbers that may be required (such as: Group #, Employee #, etc.)

____

If you have additional coverage, please complete below.

Insurance Holder's Name   Sex   Birthday   Soc. Sec. #

____

Employment ____

Insurance Company Name   Address   City   State   Zip

____

Any numbers that may be required (such as: Group #, Employee #, etc.)

____

I authorize release of any information relating to my claim.

Signature____

I authorize payment directly to Dr. ______________________.

Signature____

I understand that all fees not paid by insurance are my responsibility.

Signature____

Witness____ Date ____________________________

Note: If you have an insurance card, please give it to the receptionist so she can make a photocopy which will help in speeding your insurance claim.

COPY PINK