INSURANCE CONNECTION

Please complete, print and bring with you for your appointment the following information:

1. Student ID: _____
2. Patient name**:** _____ ___ _____
   (first) (init.) (last)
3. Policy holder full legal name _____ ___ _____
   (first) (init.) (last)
4. Policy holder's address:
   Street _____
   City _____
   State, Zip _____
5. Policy holder Date of birth**:** _____/___/_____
6. Readable current insurance card, both front and back

If covered under more than one insurance plan, please complete this form for both plans. We will need to know which plan is primary. Thank you.

If we do not receive this information, you will be billed for services provided. There is a $15 non-refundable late charge for accounts older than 30 days.