**INSURANCE INFORMATION**

Please fill out this form and address all applicable items. Thank you.

**The “insured” is the person that obtained the insurance policy** such as the employee that receives the insurance through his/her employer. The “insured” may also be the “patient” or the spouse of the “patient” or the parent of the “patient”, etc.

**Insured’s** first, middle and last name:

|  |
| --- |
|  |

**Insured** Demographics:

|  |  |
| --- | --- |
| Address: |  |
| City, State and Zipcode |  |
| Phone: |  | Date of Birth: |  |
| Email |  |
| Gender: |  |

Name of physician or other person that referred you to Daniel Benveniste, Ph.D.

|  |
| --- |
|  |

**Insured’s** Place of business:

|  |
| --- |
|  |

**Insured’s Insurance I.D. Prefix and Number**:

|  |
| --- |
|  |

Insured **Primary** Insurance Info:

|  |  |  |
| --- | --- | --- |
| Company | **Policy Group or FECA** number (Federal Employee Compensation Act)  |   |
|  |  |  |

If the Insured has a **Secondary** Insurance company list Info below:

|  |  |  |
| --- | --- | --- |
| Company | Policy Group or FECA (Federal Employee Compensation Act) Number | Insured's Insurance I.D. Prefix and Number  |
|  |  |  |

***IF THE PATIENT IS SOMEONE OTHER THAN THE INSURED***

*SUCH AS A* ***SPOUSE*** *OR* ***CHILD*** *COVERED UNDER THE UNSURED’S POLICY*

**Patient** first, middle and last name:

|  |
| --- |
|  |

**Patient** Demographics

|  |  |
| --- | --- |
| Address (if different from insured’s): | same |
|  |  |
| City, State, and Zip Code |  |
| Phone: |  | Date of Birth: |  |
| Gender: |  |
| Email: |  |

Patient’s Insurance I.D. Number and Suffix:

|  |
| --- |
|  |

Patient Relationship to the insured (spouse, parent, etc.):

|  |
| --- |
|  |