

Jennifer Lewis-Gosch, Twelve Branches Acupuncture & Herbal Medicine

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INSURANCE INTAKE FORM

PATIENT

Name _____ Date of Birth _____
Address _____ Phone (Home) _____
_____ Phone (Work) _____
Employer _____ Single _____ Married _____
Male _____ Female _____

PRIMARY PLAN INFORMATION

Plan Name _____ ID# _____
Address _____ Group # _____
_____ Phone # _____

Relationship To Insured

Self _____ Child _____
Spouse _____ Other _____

INSURED INFORMATION, IF OTHER THAN YOURSELF

Name _____
Address _____

SECONDARY INSURANCE INFORMATION

Plan Name _____ Date of Birth _____
Address _____ ID# or Claim # _____
_____ Adjuster's name _____
Phone # _____ Date of Injury _____
Name of Insured _____

I agree to the release of any medical information my health insurance may need in order to process payment. I assign some benefits to be paid to the above named provider in the event that my insurance coverage expires or denies payment.

I understand that I am personally responsible for all fees incurred unless other arrangements have been made.

Signature _____ Date _____