Diabetes Care Center
A Medical Corporation

INSURANCE REGISTRATION

Insurance cards present for scanning

PLEASE NOTE:

This is a confidential record of your medical history and will be kept in the office. Information contained here will not be released to any person except when you have authorized us to do so.

Name:_____ Date: _____

PRIMARY INSURANCE Insurance Name:_____

Insurance Address _____ Phone # _____

Subscriber ID#_____ Group # _____ Plan # _____ Coverage Begin Date: _____

Annual Deductible_____ Co-payment_____ Insureds Name _____

Insureds Date of Birth_____ Insureds Sex M / F Insureds Phone #_____

Insureds Social Security # _____ Insureds Address _____

City _____ State _____ Zip Code _____

Insureds Employer _____Employer's Phone # _____

Employer's Address _____City _____ State _____Zip Code _____

SECONDARY INSURANCE Insurance Name:_____

Insurance Address _____ Phone # _____

Subscriber ID#_____ Group # _____ Plan # _____ Coverage Begin Date: _____

Annual Deductible_____ Co-payment_____ Insureds Name _____

Insureds Date of Birth_____ Insureds Sex M / F Insureds Phone #_____

Insureds Social Security # _____ Insureds Address _____

City _____ State _____ Zip Code _____

Insureds Employer _____Employer's Phone # _____

Employer's Address _____City _____ State _____Zip Code _____

I authorize payment of medical benefits be made directly to the physician provider for services rendered. I am financially responsible for all co-payments and non-covered services. I authorize any insurance company, organization, employer, hospital, physician or pharmacist to release any information to this claim and the expenses reported, either by mail, fax or electronically.

Date:_____ Signature (Insured or Authorized): _____