



INSURANCE INFORMATION

Today's Date: _____

RESPONSIBLE PARTY INFORMATION

Last Name: _____ First: _____ MI: _____

SSN: _____ Driver's License Number: _____ State: _____

Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

PRIMARY INSURANCE

Primary Insurance Carrier: _____ Telephone: _____

ID Number: _____ Group Number: _____

Plan Number: _____ Are you the Primary Card Holder? Yes No

SECONDARY INSURANCE

Secondary Insurance Carrier: _____ Telephone: _____

ID Number: _____ Group Number: _____

Plan Number: _____ Are you the Primary Card Holder? Yes No

ASSIGNMENT & RELEASE

I, the undersigned, have insurance coverage with: _____ (Name of Insurance Company) and assign directly to **Pride Medical, Inc.** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Pride Medical, Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Patient or Legal Guardian

Date