PLEASE CHECK ALL THAT APPLY:

_____I am retired
_____I am disabled
_____I have more than one health insurance plan.
_____I receive my health insurance through MY place of employment
_____I receive my health insurance through my spouse.
(If yes, please answer the following:_____Name of spouse
_____DOB
_____SS#
_____employer

****

I authorize Drs.Kroopnick & Sherman,P.A. to apply for benefits on my behalf for services rendered. I request payment from _____ to be made
enter your ins.co.name here
directly to Drs. Kroopnick & Sherman, P.A.

_____Date:_____
Signature of subscriber

I certify that all the information I have reported is correct ,and further I authorize the release of any necessary information including medical information for this or any related claim to_____. I permit a copy of this
enter your Insurance co. name here
authorization to used in place of the original. The authorization may be revoked by me at any time in writing.

_____Date:_____
Patient's Signature

PLACE COPY OF INS.CARD HERE

_____Initials
_____Insurance verified