Pre-Visit Insurance Verification

Patient's Name:_____ **DOB**:_____ **Gender**: M / F

Primary Insurance Holder Name:_____ DOB:_____

Address: _____

Contact Information: Home_____ Cell:_____

Insurance Name: _____ **Insurance Tel #**: _____

HMO/PPO: _____ (If HMO, are we selected as PCP) **Y / N**

Insurance ID for the Patient:_____ (family ID if family Plan)

Secondary Insurance: _____

If for well visit, call ins to verify date of last Physical if child >2:_____

Call insurance to verify copays for well and sick visits: **Sick:**_____ **Well:**_____

If they have a deductible, amount: $_____ and what percent/amount they have met: $_____.

If coming for well visit, remind family to bring immunization chart: _____