

**Health Insurance Information**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work# \_\_\_\_\_

Date of Birth \_\_\_\_\_

SS# \_\_\_\_\_ Date of Injury \_\_\_\_\_

Referring Dr. \_\_\_\_\_

Diagnosis Codes: \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_

Insurance Phone \_\_\_\_\_ Fax \_\_\_\_\_

ID # \_\_\_\_\_

Name of Insured \_\_\_\_\_

Insured's date of birth \_\_\_\_\_

Your relationship to Insured \_\_\_\_\_ Insured's sex \_\_\_\_\_

**Verification**

**What is annual massage benefit limit?** \_\_\_\_\_

**How many massages allowed?** \_\_\_\_\_ **how many available?** \_\_\_\_\_

**Deductable Met? Yes No Amount?** \_\_\_\_\_

**Is there a Co-Pay? Yes No Amount?** \_\_\_\_\_

**Does tx need prescription and referral?** \_\_\_\_\_