Acupuncture Center of Andover

Patient Billing Information

Patient's Information:

Last _____ First _____ MI _____

Street _____ City _____ State _____ Zip_____

Tel (H) _____ Tel (M) _____ Tel (W) _____

DOB_____/_____/_____ Marital Status (circle one): S M D Other

Employed? Y / N Employer _____

FT / PT Student? Y / N

Insured's Information

Insurance Plan / Program _____

Group ID Number _____ Policy Number _____

Employer _____ DOB _____/_____/_____

Last _____ First _____ MI _____

Relation to Patient _____ Phone _____ Sex: M / F Other

Street _____ City _____ State _____ Zip_____
(If different than above)

Is There Another Insurance Plan? Y / N

Insurance Plan / Program _____

Group ID Number _____ Policy Number _____

* Complete the Following ONLY If Applicable *

Is your injury related to:

(Circle One) Workman's' Comp Y / N Date of Injury _____/_____/_____

Auto Accident Y / N Date of Injury _____/_____/_____

Attorney's Name _____ Phone _____

OFFICE USE ONLY **

Diagnosis Code(s):