



VEIN AND LASER — C E N T E R —

The Doctor's Offices of Sherman Hospital
915 Center Street, Suite 1000
Elgin, IL 60120

847.717.3265

Insurance Information

Please provide our receptionist with your Driver's License and your primary and secondary insurance cards so we may make a copy of these cards to keep in your file.

Please complete the following information, then sign and date below:

Patient Name: _____ Patient Social Security Number (*Required*): _____

Name of your Primary Insurance Company: _____

If the above Primary Insurance Policy is **NOT** in your name, please provide the following information:

Name of the Policy Holder: _____ Your Relationship: _____

Date of Birth of the Policy Holder: _____ Social Security Number of Policy Holder: _____
(*Required*) (*Required*)

Who is the insured's employer? _____
(*Required*)

Name of your Secondary Insurance Company: _____

If the above Secondary Insurance Policy is **NOT** in your name, please provide the following information:

Name of the Policy Holder: _____ Your Relationship: _____

Date of Birth of the Policy Holder: _____ Social Security Number of Policy Holder: _____
(*Required*) (*Required*)

Who is the insured's employer? _____
(*Required*)

Authorization: I authorize the release of medical information necessary to process this claim or provide medical information to my insurance carriers, or to any physician or medical facility. I authorize payment of benefits to the Vein and Laser Center of Elgin Cardiac Surgery for all professional goods and services rendered. I understand I am financially responsible for any charges whether or not covered by insurance.

Patient Signature: _____ Date: _____