LANSDOWNE INTERNAL MEDICINE, LLC

PATIENT REGISTRATION FORM

Section III: **Insurance Information**

Primary Insurance

Name of Policy Holder:_____ DOB:_____ Relationship to Patient:_____

SSN#:_____ Name of Employer:_____ Work Phone: (____)_____

Insurance Company:_____ ID#:_____ Group#:_____

Policy Effective Date:_____

Insurance Company Claims Address:_____Insurance Company Phone Number: (____)_____

Secondary Insurance

Name of Policy Holder:_____ DOB:_____ Relationship to Patient:_____

SSN#:_____ Name of Employer:_____ Work Phone: (____)_____

Insurance Company:_____ ID#:_____ Group#:_____

Policy Effective Date:_____

Insurance Company Claims Address:_____Insurance Company Phone Number: (____)_____

Tertiary Insurance

Name of Policy Holder:_____ DOB:_____ Relationship to Patient:_____

SSN#:_____ Name of Employer:_____ Work Phone: (____)_____

Insurance Company:_____ ID#:_____ Group#:_____

Policy Effective Date:_____

Insurance Company Claims Address:_____Insurance Company Phone Number: (____)_____

I understand and agree that I am ultimately responsible for payment. I certify that this information is true and accurate to the best of my knowledge.

_____
Signature

_____
Date

_____
Accepted By