Emmaus Surgical Center
57 Route 46, Suite 104
Hackettstown, , NJ 07840
Tel: 908-813-9600

Patient Insurance Verification

Name: _____ If a Minor, Parents Name: _____

Address: _____

_____

Home Phone Number: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: □ Female □ Male

Social Security Number: _____ Marital Status: □ Single □ Married □ Divorced □ Widowed

Emergency Contact Name: _____ Contact's Phone Number: _____

Relationship to Patient: □ Self □ Spouse □ Parent □ Other

Employer's Name: _____ Occupation: _____

Primary Insurance Company (Please provide a legible copy of your insurance card.)

Name of Insured: _____ Relationship to Patient: □ Self □ Spouse □ Parent □ Other

Social Security Number of Insured: _____ Date of Birth of Insured: _____

Name of Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone Number: _____

Insurance ID Number: _____ Insurance Group Number: _____

Secondary Insurance Company (Please provide a legible copy of your insurance card.)

Name of Insured: _____ Relationship to Patient: □ Self □ Spouse □ Parent □ Other

Social Security Number of Insured: _____ Date of Birth of Insured: _____

Name of Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone Number: _____

Insurance ID Number: _____ Insurance Group Number: _____

Accident Cases

Accident Date: _____ Adjustor's Name: _____

Carrier's Name: _____ Claim Number: _____

Carrier's Address: _____

_____

Patient/Parent's/Guardian's Signature