INSURANCE DISCLOSURE FORM

1) Patient Name(print):_____
Current Employer: _____
Insurance name: _____HMO(Yes/No) _____
Member ID _____ Group ID _____
Vision Insurance: _____ Vision ID _____
LAST 12 MONTHS:
Previous Employer within the last year: _____
Insurance name: _____HMO(Yes/No) _____
Member ID _____ Group ID _____
Vision Insurance: _____ Vision ID _____

2) Spouse/Partner/Custodial Guardian/Non-custodial Guardian 1
Name (print): _____
Phone: _____ Address:_____
Date of Birth: _____ Gender: _____ Relationship to Patient: _____
Current Employer: _____
Insurance name: _____HMO(Yes/No) _____
Member ID _____ Group ID _____
Vision Insurance: _____ Vision ID _____
LAST 12 MONTHS:
Previous Employer within the last year: _____
Insurance name: _____HMO(Yes/No) _____
Member ID _____ Group ID _____
Vision Insurance: _____ Vision ID _____

3) Spouse/Partner/Custodial Guardian/Non-custodial Guardian 2
Name (print): _____
Phone: _____ Address:_____
Date of Birth: _____ Gender: _____ Relationship to Patient: _____
Current Employer: _____
Insurance name: _____HMO(Yes/No) _____
Member ID _____ Group ID _____
Vision Insurance: _____ Vision ID _____
LAST 12 MONTHS:
Previous Employer within the last year: _____
Insurance name: _____HMO(Yes/No) _____
Member ID _____ Group ID _____
Vision Insurance: _____ Vision ID _____

Please include any additional information about employment, custody and guardianship that might be helpful in seeking reimbursement for medical services

_____

_____

4) Spouse/Partner/Custodial Guardian/Non-custodial Guardian 3

Name (print): _____

Phone: _____ Address:_____

Date of Birth: _____ Gender: _____ Relationship to Patient: _____

Current Employer: _____

Insurance name: _____HMO(Yes/No) _____

Member ID _____ Group ID _____

Vision Insurance: _____ Vision ID _____

LAST 12 MONTHS:

Previous Employer within the last year: _____

Insurance name: _____HMO(Yes/No) _____

Member ID _____ Group ID _____

Vision Insurance: _____ Vision ID _____

5) Spouse/Partner/Custodial Guardian/Non-custodial Guardian 4

Name (print): _____

Phone: _____ Address:_____

Date of Birth: _____ Gender: _____ Relationship to Patient: _____

Current Employer: _____

Insurance name: _____HMO(Yes/No) _____

Member ID _____ Group ID _____

Vision Insurance: _____ Vision ID _____

LAST 12 MONTHS:

Previous Employer within the last year: _____

Insurance name: _____HMO(Yes/No) _____

Member ID _____ Group ID _____

Vision Insurance: _____ Vision ID _____

I, _____, certify that all insurance on file and listed in this form are correct to the best of my knowledge. I understand that when a patient is covered under both Private and State insurances, the State will only pay for patient responsibilities (Copayment, CoInsurance, and Deductibles) with proof of Explanation of Payment (EOP) from ALL Private insurances. I will notify **Thao Nguyen Tran MD SC** of all changes in health insurance information within 12 months of the date of service**.**

Patient (Signed and Dated) _____

Name of Person complete this form (print): _____

Person complete this form (Signature) _____ DATE_____

Office Staff Name: _____

Office Staff (Signature) _____ DATE_____