

1. Health insurance Coverage Medicare Medicaid Group plan Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				2. Patient relationship to insured Self Spouse Child Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				3. Insured's ID Number																																																																																					
4. Patient's Name				5. Patient Birth date		6. Insured's Birth Date																																																																																							
7. Street Address				8. City		9. State																																																																																							
10. Zip Code				11. Telephone		12. Alternate Telephone																																																																																							
13. Is Patient's Condition Related to: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"> a. Employment <input type="checkbox"/> Yes <input type="checkbox"/> No </td> <td style="width: 33%; border: none;"> b. Auto Accident <input type="checkbox"/> Yes <input type="checkbox"/> No </td> <td style="width: 33%; border: none;"> c. Other Accident <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> </table>								a. Employment <input type="checkbox"/> Yes <input type="checkbox"/> No	b. Auto Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	c. Other Accident <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																			
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14. Diagnosis or nature of illness or injury <table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border: none;">a.</td> <td style="width: 25%; border: none;">b.</td> <td style="width: 25%; border: none;">c.</td> <td style="width: 25%; border: none;">d.</td> </tr> <tr> <td style="border: none;">e.</td> <td style="border: none;">f.</td> <td style="border: none;">g.</td> <td style="border: none;">h.</td> </tr> <tr> <td style="border: none;">i.</td> <td style="border: none;">j.</td> <td style="border: none;">k.</td> <td style="border: none;">l.</td> </tr> </table>								a.	b.	c.	d.	e.	f.	g.	h.	i.	j.	k.	l.																																																																										
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15. Claims <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2"></th> <th colspan="6">Dates of Service</th> <th rowspan="2">Procedure, service or supplies Description</th> <th rowspan="2">Charges</th> <th rowspan="2">Amount Paid</th> </tr> <tr> <th>FROM</th> <th colspan="5">TO</th> </tr> </thead> <tbody> <tr> <td>a.</td> <td></td><td></td><td></td><td></td><td></td><td></td> <td></td> <td></td> <td></td> </tr> <tr style="background-color: #e6f2ff;"> <td>b.</td> <td></td><td></td><td></td><td></td><td></td><td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>c.</td> <td></td><td></td><td></td><td></td><td></td><td></td> <td></td> <td></td> <td></td> </tr> <tr style="background-color: #e6f2ff;"> <td>d.</td> <td></td><td></td><td></td><td></td><td></td><td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>e.</td> <td></td><td></td><td></td><td></td><td></td><td></td> <td></td> <td></td> <td></td> </tr> <tr style="background-color: #e6f2ff;"> <td>f.</td> <td></td><td></td><td></td><td></td><td></td><td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>g.</td> <td></td><td></td><td></td><td></td><td></td><td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>									Dates of Service						Procedure, service or supplies Description	Charges	Amount Paid	FROM	TO					a.										b.										c.										d.										e.										f.										g.									
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