

Douglas C.A.R.E.S.
256 SE Stephens, Roseburg, OR 97470
Phone (541) 957-5646

MEDICAL INSURANCE INFORMATION SHEET

CHILD INFORMATION:

Full Name (Last, First, Middle Initial): _____
Mailing Address: _____ City: _____ Zip: _____
Street Address: _____ City: _____ Zip: _____
SS #: _____ Age: _____ Date of Birth: _____
Home Phone: _____

RESPONSIBLE PARTY

Full Name: _____
SS#: _____
Date of Birth: _____
Address: _____
Home Phone: _____
Employer: _____
Employer Address: _____
Work Phone: _____

INSURANCE INFORMATION

Insured: _____ DOB: _____
Relationship to patient: _____
Insurance Co: _____
Policy/Group #: _____
ID#: _____
Address: _____

AUTHORIZATION TO PAY – RELEASE MEDICAL INFORMATION

I hereby authorize Douglas CARES to release any medical information necessary to process a claim. I hereby assign all payments due from my insurance company directly to Douglas CARES. Douglas CARES will not charge the Parent / Guardian in the case of denied coverage, the portion your insurance doesn't pay or when there is no insurance.

Signature: _____ Date: _____