Synergique Healing, PA

Behavioral Health & Functional Medicine

Updating Insurance Information

PATIENT INFORMATION

Patient's Name_____ Date of Birth_____

Address:_____ Apt#/Unit_____

City:_____, State:_____ Zip:_____

Phone#_____ Email:_____

NEW INSURANCE INFORMATION

Type of Insurance: ☐ PPO ☐ HMO ☐ Other

Insurance Name:_____

Member ID:_____ Group#:_____

Provider/ Customer Service Number:_____

Policy holder's Name:_____ Their date of birth:_____

Social Security Number:_____ Relationship to patient:_____

By signing this document, I attest that all the statements I have made to all the questions are true and correct to the best of my knowledge and belief.

Signature:_____ Date:_____

Name and relationship to Patients (If differ.):_____

**If signed electronically*, Date of Birth of signer:_____ Phone#:_____

Witness Name: _____ Witness Signature: _____