



**Please Print**

**INSURANCE INFORMATION**

\_\_\_\_\_  
Name of Insurance Company

\_\_\_\_\_  
I.D. or Contract Number

\_\_\_\_\_  
Policy Holder's Name

\_\_\_\_\_  
Service Code Number or Insurance Number

(\_\_\_\_\_)\_\_\_\_\_  
Policy Holder's Phone Number

\_\_\_\_\_  
Group Numbers or Policy Numbers

\_\_\_\_\_  
Policy Holder's Address State Zip

\_\_\_\_\_  
Relationship to Minor

**PARENT INFORMATION**

I request that payment under my medical insurance program be made directly to the site of services rendered. I understand that I am financially responsible for fees not covered by this authorization.

\_\_\_\_\_  
Name of Parent/Guardian

\_\_\_\_\_  
Address

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
City State Zip

(\_\_\_\_\_)\_\_\_\_\_  
Home Phone

(\_\_\_\_\_)\_\_\_\_\_  
Work Phone

(\_\_\_\_\_)\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Date