Doorways, LLC

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Insurance Information

Date: _____

Client's Legal Name _____
Date of Birth _____ Age _____ Client's SS# _____
Employed: ☐ Full-Time ☐ Part-Time Student: ☐ Full-Time ☐ Part-Time Gender: ☐ M ☐ F
Address _____
City _____ State _____ Zip _____
Phone _____ Email Address _____

PRIMARY INSURANCE

Patient's Relationship to Subscriber: Self, Spouse, Child, Other _____

Subscriber's Name _____ DOB_____
Subscriber's SS# _____ Gender: ☐ M ☐ F
Address _____ City _____ State _____ Zip Code _____

Insurance Company Name _____

Subscriber's ID # _____ Policy Group # _____
Plan Name _____ Insurance Start Date: _____

Subscriber's Employer Name or School Name _____

SECONDARY INSURANCE

Subscriber's Name _____ DOB_____
Subscriber's SS# _____ Gender: ☐ M ☐ F
Address _____ City _____ State _____ Zip Code _____

Insurance Company Name _____

Subscriber's ID # _____ Policy Group # _____
Plan Name _____ Insurance Start Date _____

Subscriber's Employer Name or School Name _____

OTHER IMPORTANT INFORMATION

- You must bring your current insurance card and picture ID.
- It is your responsibility to know your insurance coverage. Please note that possession of your insurance card does not guarantee eligibility of benefits.
- Any co-pays/coinsurance percentages are expected to be paid at the time of your visit.