Lake Jackson
Ear, Nose and Throat

Patient Insurance Form

Note: Please make sure you provide us a copy of each insurance card. if your insurance changes, please let us know so we can update your records.

Patient Information

Last Name | First Name | Middle initial | Nickname / AKA

First (Primary) Insurance Information

Insurance Company Name | Insurance Holder Name | Date of Birth | Employer Name

Policy # | Group #

Home Address (if different than patient's) | Apt # | City | State | Zip

Relationship to Patient ☐ Self ☐ Parent ☐ Spouse ☐ Other

Second (Secondary) Insurance Information

Insurance Company Name | Insurance Holder Name | Date of Birth | Employer Name

Policy # | Group #

Home Address (if different than patient's) | Apt # | City | State | Zip

Relationship to Patient ☐ Self ☐ Parent ☐ Spouse ☐ Other

Assignment Of Benefits: I hereby assign all medical benefits to which I might be entitled, including Medicare, Medicaid, Private Insurance or Worker's Compensation (this list is not all inclusive) to Stephanie Herrera, MD and Associates, PA for services provided to myself and/or my dependents and not yet paid in full. I hereby authorize and direct my insurance carrier to issue payment directly to the provider listed. A photocopy of this assignment is to be considered as valid as the original.

Signature of Patient/Legal Guardian | Date