| E. Thomas Arne Jr., D.O., F.A.C.C.1250 S. Tamiami Trail Suite 401Sarasota, Florida 34239Office: 941-366-2194 Fax:941-366-7025[www.gulfshorepc.com](http://www.gulfshorepc.com)  |  |  | IMG_4682 |
| --- | --- | --- | --- |

**PATIENT INSURANCE INFORMATION**

Page 1 of 2

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_

**PRIMARY INSURANCE**

**Insurance Company Name Group #` Subscriber #**

|  |  |  |
| --- | --- | --- |
|  |  |  |

**Insured First Name Last Name Middle Initial**

|  |  |  |
| --- | --- | --- |
|  |  |  |

**Social Security # Date of Birth Phone # Relation to Patient**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

**Address City State Zip Code**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

**Insured Employed by Business Phone #**

|  |  |
| --- | --- |
|   |  |

**Address City State Zip Code**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

**PATIENT INSURANCE INFORMATION (continued)**

Page 2 of 2

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I am / am not covered by additional insurance. (Circle one)**

**ADDITIONAL INSURANCE**

**Insurance Company Name Group #` Subscriber #**

|  |  |  |
| --- | --- | --- |
|  |  |  |

**Insured First Name Last Name Middle Initial**

|  |  |  |
| --- | --- | --- |
|  |  |  |

**Social Security # Date of Birth Phone # Relation to Patient**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

**Address City State Zip Code**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

**Insured Employed by Business Phone #**

|  |  |
| --- | --- |
|   |  |

**Address City State Zip Code**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

**YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT.**

**BY SIGNING BELOW, I ATTEST THAT THE INFORMATION PROVIDEDABOVE IS TRUE AND ACCURATE.**

**Patient’s Signature Date**

|  |  |
| --- | --- |
|  |  |