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713-869-7404 FAX

Tax ID # 271577881
NPI# 1487635892 BG
NPI# 1821157363 CW
NPI# 1831561901 AW
NPI# 1578106217 SE

PRIMARY INSURANCE INFORMATION

Patient Name: _____ DOB: _____

Policy Holder's Name: _____ DOB: _____

Policy Holder's Employer: _____

No insurance: Self pay _____

Insurance: _____

Insured S.S. # _____

Relationship to Patient: Self Spouse Child Other _____

Subscriber ID Number: _____ Group Number: _____

Assignment and Release

I certify that all insurance information is true and accurate. You are required to notify the office of any insurance changes. I the undersigned, have insurance coverage with _____ and assign directly to Dr. Gritz's office all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all my insurance submissions.

_____

Signature of Patient or Parent/ Guardian Date

OFFICE USE ONLY BELOW
Benefit Phone Number _____

Co-Pay Amount _____ DED Amount _____