Whitebridge Pulmonary Care
Insurance Information Form

Date: June 23, 2025

Please complete the following insurance information for our records.

Patient Information

Full Name: _____

Date of Birth: _____ Phone Number: _____

Primary Insurance

Insurance Company Name: _____

Policy Number: _____ Group Number: _____

Policyholder's Name: _____

Relationship to Patient: _____

Policyholder's Date of Birth: _____ Phone: _____

Secondary Insurance (if applicable)

Insurance Company Name: _____

Policy Number: _____ Group Number: _____

Policyholder's Name: _____

Relationship to Patient: _____

Policyholder's Date of Birth: _____ Phone: _____

Authorization

I authorize Whitebridge Pulmonary Care to release any information required to process my insurance claims. I authorize my insurance benefits to be paid directly to Whitebridge Pulmonary Care.

Signature: _____ Date: _____