PRIMARY INSURANCE HOLDER INFORMATION

THIS INFORMATION IS FOR THE WALK-IN CLINIC

TYPE OF INSURANCE____________________ CONTRACT #_________________GROUP #_________

POLICY #____________________________________

NAME (FIRST, M.I. LAST____

GENDER: __MALE __FEMALE DATE OF BIRTH____/____/____

MAILING ADDRESS____

CITY__________________________ STATE__________________ ZIP_______________

SOCIAL SECURITY #____- ____- _____ HOME PHONE#__________________________________

EMPLOYER____

IS THIS INSURANCE THROUGH THIS EMPLOYER? __YES __NO COPAY AMOUNT: ____________

WHEN CHECKING IN AT CAMP SANCTA MARIA, WE WILL REQUIRE:

1. A COPY OF THE FRONT AND BACK OF THE POLICY HOLDERS' INSURANCE CARD.
2. YOUR PHOTO ID

PLEASE US AT 248-822-8199 IF YOU HAVE ANY QUESTIONS.

THANK YOU , AND GOD BLESS YOU!

CAMP SANCTA MARIA