Insurance Information

PLEASE PROVIDE A COPY OF CARD

☐ Medicare ☐ SoonerCare ☐ CDIB Beneficiary Yes No
Tribe: _____

☐ Other: _____ ☐ Private Insurance Name: _____

City: _____ State: _____ Zip: _____

Insurance ID # : _____ Group # : _____

Primary Guarantor (who carries insurance)

Social Security: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Gender (circle one): Male Female

Relationship to Patient (circle one) Self Spouse Parent Step-parent

Assignment and Release (Check one box)

☐ I, the undersigned, clarify that I (or the dependent) have the insurance coverage listed above and assign directly to Family Medical Clinic all insurance benefits, in 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 provider to release all information necessary to secure the payment of benefits.

☐ I, the undersigned, do not have insurance coverage and understand that I am financially responsible for all charges at the time services are rendered.

_____ _____
Responsible Party Printed Name Signature

_____ _____
Relationship Date

Note: If you do not have insurance and need help with payment arrangements please contact EOMC at 918-635-3302. Your child's health is our priority and we want to make sure care is provided.