Money Tree Billing, LLC.
Your Chiropractic Billing Team

PATIENT INFORMATION TRANSFER

❑ **New Patient** ❑ **Existing Patient with New Insurance** (* Areas Only)

*Clinic/Doctor Name: ______________________ *Date: ______________

*Patient Name: ____
First Name Middle Initial Last

Address: ____

City, State, Zip Code: ____

Home Phone: ______________ Gender: __________ Marital Status: ______________

Date of Birth: ______________ Initial Date of Service: ______________

*Name of Insured: ____

*Insured's Date of Birth: ______________ *Relationship to Patient: ______________

*Patient Diagnosis:

*Date of Injury ______________ **Auto Related:** [ ] Yes [ ] No **Work Related:** [ ] Yes [ ] No

IF MEDICARE PATIENT:** [ ] Acute [ ] Chronic ***NOTE: If acute, be sure to list Date of Injury above)

Enter insurance information below and attach copy of patient's insurance card.

****PRIMARY Insurance Information:***

Insurance Company Name: ____

Billing Address: ____

City, State, Zip Code: ____

Phone Number: ____

Identification/Claim #: ______________ Group #: ______________

****SECONDARY Insurance Information:***

Insurance Company Name: ____

Billing Address: ____

City, State, Zip Code: ____

Phone Number: ____

Identification/Claim #: ______________ Group #: ______________

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