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Board Certified
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Tax ID # 126549629
NPI # 1487635892 BG
NPI# 1821157363 CW
NPI#1831561901 AW

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 _____