INSURANCE LOG

PATIENT'S NAME:					PHONE:		
ADDRESS:					ZIP:		
PATIENT'S SC	C. SEC. NO			BIRTHDATE: _			
INSURED'S NAME (If not Patient)					PHONE:		
POLICYHOLDER (i.e. EMPLOYER)					PHONE:		
ADDRESS:					ZIP:		
INSURANCE COMPANY:					PHONE:		
ADDRESS:					ZIP:		
NAME OF EXA	MINER OR AG	ENT:	.	····			
CLAIM NO POLICY NO					GROUP NO.		
PAYROLL NO CONTROL NO					CERT. NO		
EFFECTIVE	ATE:		EXPI	RATION DATE			
ATTORNEY'S	NAME:			PHO	ONE:		
ADDRESS:				ZIP			
REMARKS:							
COVERAGE:_							
	JRY/ ACCIDEN	Т:			ASSIGNMENT: Y		
DATE	AMOUNT BILLED	BILL SENT TO	DATE PAID	AMOUNT PAID	PAID BY	BALANCE	
