

# McCarter Chiropractic and Rehabilitation Center

## INSURED INFORMATION

ALL BLANKS MUST BE COMPLETED TO INSURE THAT YOUR  
INSURANCE WILL BE BILLED TIMELY

(PLEASE PRINT NEATLY)

PATIENT'S NAME \_\_\_\_\_ DATE \_\_\_\_\_

INSURED'S NAME  
\_\_\_\_\_

RELATIONSHIP TO INSURED Please Check One

\_\_\_ SELF \_\_\_ SPOUSE \_\_\_ NATURAL CHILD \_\_\_ STEP CHILD \_\_\_ OTHER

INSURED'S  
ADDRESS  
\_\_\_\_\_  
\_\_\_\_\_

INSURED'S PHONE  
\_\_\_\_\_

INSURED'S DATE OF  
BIRTH  
\_\_\_\_\_

INSURED'S SOCIAL SECURITY  
\_\_\_\_\_  
\_\_\_\_\_

INSURED'S  
EMPLOYER  
\_\_\_\_\_