NORTHERN LIGHTS PEDIATRIC & ADOLESCENT MEDICINE

CHANGE OF INSURANCE INFORMATION
HAVE YOUR INSURANCE CARD COPIED

NEW INSURANCE COMPANY NAME ___________________________________

NEW INSURANCE POLICY, ID OR SS # _________________________________

NEW INSURANCE GROUP # ____

POLICY HOLDER'S NAME ____

POLICY HOLDER'S BIRTHDATE_________________

RELATIONSHIP: Parent___ Step Parent___ Grandparent___ Other___

Was this insurance effective last month? ___Yes **Effective Date** ___________No____

IS THERE OTHER INSURANCE IN EFFECT? ___Yes ___No

If yes, what is the other insurance? ____

Who is the policyholder? ____

Birthdate_______________ Parent___ Step Parent___ G'parent___ Other___

CHILDREN IN YOUR HOUSEHOLD THE NEW INSURANCE COVERS

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I hereby authorize payment of medical benefits due to me under the terms of my policy to Northern Lights Pediatric & Adolescent Medicine. I understand the clinic's charge may exceed the insurance company payment and if greater than such, I will be responsible for paying that additional allowable amount.

Signed____Date_______________
Signature of parent or guardian

I hereby authorize Northern Lights Pediatric & Adolescent Medicine to furnish any medical or other information necessary to process claims by my insurance company.

Signed____Date_______________
Signature of parent or guardian

8/26/08

NORTHERN LIGHTS PEDIATRIC & ADOLESCENT MEDICINE

CHANGE OF ADDRESS

Patient Name ____ DOB __________________

NEW Address ____

City ________________________________ State ________ Zip __________________

Home Phone Number ____

WHO MOVED TO THIS ADDRESS?

Father ____
(name)

Mother ____
(name)

Child ____

Child ____

Child ____

Child ____

8/26/08