Dr. Virginia Hobday & Associates
P.O. Box 11786, Grand Cayman, KY1-1009,
Cayman Islands
Telephone: (345) 949-7400, Fax: (345) 949-9045

INSURANCE INFORMATION - PRIMARY INSURANCE

Are you Insured? Yes No

Insurance Company ______________________________

Group # ______________________ Policy/ID # ______________________

Primary Insured Person: ______________________________

Please fill out the following if Primary Insured is different from Patient:

Date of birth: _____ /_____ /_______
day/month/year

Phone: ______________________

Address ______________________________

____

Relation to Patient: Self Child Spouse Other

Insured's Employer: ______________________________

Occupation: ______________________________

Business Address: ______________________________

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Business Phone: ______________________

I, the undersigned certify that I (or my dependant) have insurance coverage with ______________________________ and assign directly to Dr. Virginia Hobday and Associates all insurance 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 doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all submissions.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:

Signed: ______________________________ Date: ______________

Signed by parent or guardian if patient is a minor: ______________________________