Agnesian Work and Wellness
(920) 926-5666 / (920) 745-3590

Health Insurance Demographic Form

Complete the information below to assist with proper Health Insurance billing for Flu Vaccinations.

Patient Information

Full Legal Name _____
First M. I. Last

Previous Name (if apply) _____
First M. I. Last

Date of Birth _____ **Primary Phone Number** _____

Street Address _____

City _____ **State** _____ **Zip** _____

Gender: M or F (circle one) **Status:** Married / Single / Divorced / Widowed (circle one)

Employer Name _____ **Employment status:** Full or Part Time

Insurance Information

Health Insurance Guarantor Information (primary person on insurance)

Full Legal Name _____
First M. I. Last

Date of Birth _____ **Primary Phone Number** _____

Street Address _____

City _____ **State** _____ **Zip** _____

Relationship to Patient _____

Employer Name _____ **Employment status:** Full or Part Time

Research your insurance plan and how the flu vaccine charge is covered under the benefit plan. Validate SSM Healthcare is within your plan to cover Flu vaccinations. If full cost is not covered, patient will be responsible for the difference.

Patient Signature: _____

COPY of INSURANCE CARD's FRONT & BACK MUST BE ATTACHED to FORM