MAPLEGROVE TREATMENT CENTER

1827 River Lakes rd. S Oconomowoc, WI 53066
Clinic Office: 262-510-4447
Billing Office: 262-646-1387
info@maplegrovetreatmentcenter.com

****Be sure to attach a copy of your insurance card when sending in this form****

INSURANCE REGISTRATION FORM
(PLEASE PRINT)

DATE____________ HOME PHONE_________________

PATIENT____
Last Name First Name Middle

Responsible Party (if a minor)____

Street Address____

City______________________________ State___________ Zip_____________

Sex: M F Age________ Patient's Birthdate__________________

Insured employer____

Business Address____

Occupation_______________________ Business Phone_______________________

Spouses Name___________________________ Insured's Birthdate______________________

Who is responsible for this account?___________________ Relationship to pt_____________

Social Security #___________________Spouse's Social Security #_____________________

Do you have Medical Insurance? Yes No Subscriber____________________________

Name of Primary Insurance Carrier____

Claims address____

Subscriber #_______________________ Group #_____________________________

Name of Secondary Insurance (if any)____

Subscriber #_______________________ Group #_____________________________

I acknowledge that I have received a copy of patient rights & responsibilities and billing policy, and that I am responsible for payment for treatment and services. I give consent to Maplegrove Treatment Center for treatment.

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Signature date