Dr J J Soares
HMC Burnaby Urgent Care & Medical Imaging
10-12 Burnaby Street
Hamilton HM 11

Patient Insurance Information

Mr Mrs Miss (Please circle appropriate title)

e.g. February 1st 1951

Surname _____ Birth Date _____

Given Name _____

Mailing Address _____

Parish _____ Post Code _____

Home Telephone # _____ Work Telephone # _____ Cell # _____

E-mail Address _____

Place of Employment _____

Name of Insurance Company _____

Insurance Policy Number _____ Effective Date _____

Certificate Number _____

Home & Office _____ Major Medical _____

Is this Policy in your name? _____

If not, Who's name is on the Policy? _____

Name of Policy holder (Usually the Employer) _____

Next of Kin _____ Relationship _____ Tel # _____

I, the undersigned, hereby authorise payment of Insurance benefits to the attending Physician and or laboratory for services rendered to the patient named on this form, together with the release of any information necessary to process the claim, and will be responsible for any amount not covered by my insurance.

Signature _____ Date _____