the LOVAAS CENTER
Hope for the future, proven by the past

tel: 702-877-2520 • fax: 702-877-2521 • www.thelovaascenter.org
331 North Buffalo Drive Suite B • Las Vegas, NV 89145

Client Insurance Information

Client/Patient Information

Name*: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Other _____

Address: *_____City: _____State:_____Zip: _____

Home Phone: _____ Work Phone _____

Cell Phone _____ Best number to contact you: ☐ Home ☐ Work ☐ Cell

DOB* _____/_____/_____SSN# _____

Responsible/Insured Party

Name*: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Other _____

Address: _____City: _____State:_____Zip: _____

Home Phone: _____ Work Phone _____

Cell Phone _____ Best number to contact you: ☐ Home ☐ Work ☐ Cell

DOB*_____/_____/_____**SSN#*** _____

Insurance Information

Insurance Company*:_____**Type of Plan** * ☐ HMO ☐ PPO

Name of Medical Group/IPA (If HMO)*_____

Insurance Company/Medical Group Phone :(See back of the card)_____

Member ID Number*: _____ Group Number: _____

Please make copy of both front and back of your insurance card and attach with the form.

------ ***DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING*** ------ Secondary

Insurance Company: _____Type of Plan ☐ HMO ☐ PPO

Name of Medical Group/IPA (If HMO)_____

Insurance Company/Medical Group Phone :(See back of the card)_____

Member ID Number: _____ Group Number: _____

(* Mandatory Fields) **Signature*:**