ORTHODONTIC INSURANCE INFORMATION

In order to assist you in determining your orthodontic benefits, the following information is necessary:

Name of Patient: ______________________ **Date of Birth:** ____________
Name of Insured: ______________________ **Date of Birth:** ____________
Address of Insured: ____
Soc Security # or ID #: ______________________ **Telephone #:** ____________
Employer Name: ______________________ **Telephone #:** ____________
Insurance Company: ______________________ **Group #:** ____________
Insurance Company Address: ____
Insurance Company Telephone #: ______________ **Primary or Secondary?** ____________

Is patient covered under another dental plan? If so, please complete the following information:

Name of Patient: ______________________ **Date of Birth:** ____________
Name of Insured: ______________________ **Date of Birth:** ____________
Address of Insured: ____
Soc Security # or ID #: ______________________ **Telephone #:** ____________
Employer Name: ______________________ **Telephone #:** ____________
Insurance Company: ______________________ **Group #:** ____________
Insurance Company Address: ____
Insurance Company Telephone #: ______________ **Primary or Secondary?** ____________

I hereby authorize release of any information relating to this claim.

______________________________________ **Date:** ____________
Signature

I hereby authorize payment of insurance benefits directly to the above named orthodontist.

______________________________________ **Date:** ____________
Signature

Please notify our office of any changes in your insurance policy as soon as possible, thank you.