

INSURANCE INFORMATION

If you have orthodontic insurance, please fill out this form and return it to us before your records appointment. If you are planning for us to accept assignment from your insurance company, please be sure to sign and date this form authorizing to pay benefits to the orthodontist.

Name of Primary Insurance Company: _____

Address of Insurance Company: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Patient's Name: _____ Patient's Birthdate: _____

Name of Policy Holder: _____ Policy Holder's Birthday: _____

Policy Holder's Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Group Number: _____ SS# _____

Employed by: _____ Phone# _____

Name of Secondary Insurance Company: _____

Address of Insurance Company: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Patient's Name: _____ Patient's Birthdate: _____

Name of Policy Holder: _____ Policy Holder's Birthday: _____

Policy Holder's Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Group Number: _____ SS# _____

Employed by: _____ Phone# _____

I authorize payment directly to the orthodontist of the group insurance benefits otherwise payable to me.

Responsible Party Signature: _____ Date: _____

OFFICE USE ONLY

Lifetime Max _____ Yearly Max _____ Paid out at _____ %

Deductable _____ Benefit Used _____ Benefit remaining _____

Effective Date of Coverage _____ Is there a waiting period Yes _____ No _____

Does insurance pay: Monthly _____ Quarterly _____ Automatic _____