ORTHODONTIC INSURANCE INFORMATION

In order to assist you in determining your orthodontic insurance benefit, the following information is necessary.

NAME OF PATIENT: _____BIRTHDATE_____

NAME OF POLICY HOLDER: _____BIRTHDATE_____

MAILING ADDRESS OF POLICY HOLDER: _____

SOCIAL SECURITY NUMBER OR ID NUMBER OF POLICY HOLDER: _____

EMPLOYED BY: _____

EMPLOYER ADDRESS: _____

INSURANCE COMPANY: _____

INSURANCE COMPANY ADDRESS: _____

INSURANCE TELEPHONE NUMBER: _____

POLICY/GROUP NUMBER: _____

I hereby authorize release of any information relating to this claim to the insurance company

Signature _____Date _____

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

Signature_____Date_____

PLEASE NOTIFY OUR OFFICE OF ANY CHANGES IN YOUR INSURANCE COVERAGE AS SOON AS POSSIBLE