ORTHODONTIC INSURANCE INFORMATION

☐ New Insurance ☐ Additional/Secondary Insurance

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

Name of Patient: _____ Date of Birth: _____

Name of Policy Holder: _____ Date of Birth: _____

Relationship to Patient: _____

Policy Holder Employer: _____

Address of Policy Holder: _____

Contact #: _____ Policy Holder Social Security #: _____-_____-_____

Name of Dental Insurance: _____ Insurance Telephone: _____

Member ID#_____ Policy/Group/ID #:_____

Address of Insurance Company: _____

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

BENEFITS ARE NOT A GUARANTEE OF PAYMENT!

Please notify our office of any changes in your Insurance as soon as possible

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FOR OFFICE USE ONLY

BENEFIT AMOUNT $	BENEFIT USED $
DEDUCTIBLE:	PAYS AT:
AGE LIMIT:	PRE AUTH REQUIRED:
WAITING PERIOD:	COVERS WORK IN PROG:
PLAN TYPE: HCR PLAN?	PAYER ID:
METHOD OF PMT:	PAYS OUT OF NETWORK:
STAFF WHO VERIFIED:	EFFECTIVE DATE:
TODAYS DATE:	SPOKE WITH: