ORTHODONTIC INSURANCE INFORMATION

Date: _____

***Patient Name:** _____ ***Patient Birthday** _____

***Insured Name:** _____

***Insured Address:** _____

***Insured Birthday** _____ **Relationship to Patient** _____

***Social Security Number** _____ ***Employer Name:** _____

***Insurance Company** _____

***Insurance Company Address** _____

***Insurance Group #** _____ **Member I.D. #** _____

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

Signature: _____ **Date:** _____

Office Use Only

Spoke with: _____

Percentage of Orthodontic Coverage: _____ **Age Limit** _____

Lifetime Maximum: _____ **Yearly Maximum:** _____

Effective Date: _____ **Benefit Used:** _____

How are benefits paid? Monthly __ Quarterly __ Other _____ Auto _____

Is there a Deductible: One-Time ____ Yearly ____ $_____

Do you accept **electronic claims:** _____ **Payer I.D.** _____

Additional Information: _____

_____