

Insurance Information

CARRIER # _____

Patient Name _____

Patient's Birthday _____

Relationship to Policyholder: (circle one) self spouse dependent child other

POLICYHOLDER

Name _____ Birthday _____ Social Security # or Member # _____

Home Address _____

Employer _____

Insurance Carrier _____

Employer's Address:

Insurance Carrier's Mailing Address:

Policy or Group # _____

Ins. Carrier Phone # _____

Is Patient covered by any other dental plan? (circle one) Yes No

If Yes, please complete additional form for supplemental dental insurance.

I hereby certify that the above information is correct.

I authorize the release of any information relating to my orthodontic insurance claim.

Policyholder/Employee Signature Date

Policyholder/Employee Signature Date

ASSIGNMENT OF BENEFITS: (Please sign only ONE of the below)

I hereby authorize payment directly to the attending dentist.

Patient has paid attending dentist in full for the services rendered. I hereby direct benefits payable to the insured.

Policyholder/Employee Signature Date

Policyholder/Employee Signature Date

All patients with dental or orthodontic insurance coverage (which may provide benefits to be used as partial payment for orthodontic services rendered) need to complete this form as fully as possible. Any information of which you are unsure may be phoned in to our office. Incomplete information may result in delay of benefit determination. Orthodontic coverage is subject to specific limitations and exclusions according to your specific insurance plan. Please refer to your dental booklet for a description of covered expenses, deductibles, maximums, and copayment information. Benefits quoted over the phone to our office are not a guarantee of payment.