

OFFICE USE ONLY	date _____
name _____	effective _____
% _____	to age _____
maximum _____	
used to date _____	
other _____	

ORTHODONTIC INSURANCE INFORMATION

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

Name of Patient: _____ Date of Birth: _____

Name of Insured: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone: _____
(if Blue Cross/Blue Shield insurance include prefix)

Employed by: _____ Telephone: _____

Address: _____

Insurance Company: _____ Policy/Group #: _____

Address of Insurance Company: _____

Insurance Company Telephone: _____

Is patient covered under another dental plan? If so, please complete the following information:

Name of Insured: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone: _____

Employed by: _____ Telephone: _____

Address: _____

Insurance Company: _____ Policy/Group #: _____

Address of Insurance Company: _____

Insurance Company Telephone: _____

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

 Signature Date _____

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

 Signature Date _____