



Orthodontic Insurance Form

TO OUR PATIENTS WITH ORTHODONTIC INSURANCE

Our office is happy to cooperate with patients who are covered by orthodontic insurance. Dental insurance policies do not necessarily include benefits for orthodontic treatment. Please read your policy **carefully to be fully aware of its benefits as well as its limitations**. Should you still have questions about your coverage, please contact the Employee Benefits Office at your place of employment. Our business office will file your claims. We ask that you complete this form and bring it to your consultation appointment. We will enter this information into our records and any charges will be sent to your insurance company. If you do not complete this form we cannot file your insurance. **It will be your responsibility to pay any balance not covered by your orthodontic insurance benefits.**

I have read and understand the above statements: _____ (Initials)

Patient's Name: _____ Birthdate: _____

Gender: Male Female

Patient's relationship to the insured: Self Spouse Child Stepchild

PRIMARY INSURANCE

Name of Employee: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____ Social Security Number: _____

Name of Insurance Company: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Phone No. _____ Group No. _____

Employer: _____

Street Address: _____

City: _____ State: _____ Zip: _____

I authorize the release of any information relating to this claim, and hereby authorize payment directly to the dentist of the group insurance otherwise payable to me.

Signed (Insured Person) _____ Date _____

If there is more than one insurance benefit, please complete page two of this form.

SECONDARY INSURANCE

Name of Employee: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____ Social Security Number: _____

Name of Insurance Company: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Phone No. _____ Group No. _____

Employer: _____

Street Address: _____

City: _____ State: _____ Zip: _____

I authorize the release of any information relating to this claim, and hereby authorize payment directly to the dentist of the group insurance otherwise payable to me.

Signed (Insured Person) _____ Date _____