INSURANCE

Not all dental insurance plans provide orthodontic coverage. Plans that do have orthodontic benefit available usually have a lifetime maximum for each patient covered. If there are two or more plans available with orthodontic benefit, primary and secondary coverage are usually determined by whose birth date comes first in the calendar year. One exception to this rule would be a situation where a court has ordered which person carries primary insurance coverage. We would need a copy of this order for claims. If there is insurance, please provide the following information:

If the patient is employed and there is a dental plan with orthodontic coverage for the employee:

Patient's Social Security Number _____ Employee ID Number _____

Insurance Company Name _____ Insurance Company Telephone (_____)_____

Insurance Company Address _____ City _____ State _____ ZIP Code _____

Group Number _____ Policy Number _____

If the spouse is employed and there is a dental plan with orthodontic coverage available for the patient:

Spouse's Social Security Number _____ Spouse's Birth Date _____ Employee ID Number _____

Insurance Company Name _____ Insurance Company Telephone (_____)_____

Insurance Company Address _____ City _____ State _____ ZIP Code _____

Group Number _____ Policy Number _____

For patients who are dependents:

Primary Coverage:

Employees/Subscriber Name _____ Birth Date _____

Home Address _____ City _____ State _____ ZIP Code _____

Social Security Number _____ Relationship To Patient _____

Employee ID Number _____ Employer _____

Employer's Address _____ City _____ State _____ ZIP Code _____

Insurance Company Name _____ Insurance Company Telephone (_____)_____

Insurance Company Address _____ City _____ State _____ ZIP Code _____

Group Number _____ Policy Number _____

Secondary Coverage:

Employees/Subscriber Name _____ Birth Date _____

Home Address _____ City _____ State _____ ZIP Code _____

Social Security Number _____ Relationship To Patient _____

Employee ID Number _____ Employer _____

Employer's Address _____ City _____ State _____ ZIP Code _____

Insurance Company Name _____ Insurance Company Telephone (_____)_____

Insurance Company Address _____ City _____ State _____ ZIP Code _____

Group Number _____ Policy Number _____

For additional insurance coverage, please use a separate piece of paper giving all the necessary information.

I authorize release of information to all insurance companies and the use of this form for all insurance submissions. I authorize payment directly to the doctor. A copy of this authorization may be used in place of the original. To the best of my knowledge, all of the preceding information is true and correct. If there is ever any change in any of the preceding information, I will inform the doctor or other staff member at the next appointment without fail.

Signature Date