



Please check if this is:

- New Insurance
- Additional Insurance
- Change of Insurance

To Our Patients with Orthodontic Insurance:

Please take a few moments to **print** and complete this form and **bring it to your consultation appointment.** (Because we are required to have your signature, you will not be able to submit this electronically.) By bringing this form to your appointment, we will be able to save you time. Complete and accurate information is needed in order to file your insurance in a timely manner. We only require your orthodontic insurance: do not include your medical insurance. It is very important that you advise us of any changes in your insurance coverage. Thank you!

Patients Name; _____
 Birthdate; _____ Gender (please circle) Male Female
 Relationship to Employee: Self _____ Spouse _____ Child _____ Stepchild _____ Other _____

Primary Insurance

Name of Employee: _____
Street Address: _____
City: _____ **State:** _____ **Zipcode:** _____
Birthdate: _____ **Social Security #:** _____

Name of Insurance Company: _____
Street Address: _____
City: _____ **State:** _____ **Zip code:** _____
Insurance company Phone #: _____ **Group #:** _____
Subscriber I.D.#: _____
Name of Employer: _____
Street Address: _____
City: _____ **State:** _____ **Zipcode:** _____

I authorize release of any information relating to this claim:
Signed (Patient or Parent if Minor) _____ **Date:** _____

I hereby authorize payment directly to the dentist of the group insurance benefits.
Signed (Insured Person) _____ **Date:** _____

Secondary Insurance

Name of Employee: _____
Street Address: _____
City: _____ State: _____ Zip code: _____
Birthdate; _____ Social Security # _____

Name of Insurance Company: _____
Street Address: _____
City: _____ State: _____ Zip code: _____
Insurance company Phone #: _____ Group #: _____
Subscriber I.D.#: _____
Name of Employer: _____
Street Address: _____
City: _____ State: _____ Zip code: _____

I authorize release of any information relating to this claim:
Signed (Patient or Parent if Minor) _____ Date: _____

I hereby authorize payment directly to the dentist of the group insurance benefits.
Signed (Insured Person) _____ Date: _____

If there is additional insurance coverage, please list detailed information below: