



INSURANCE INFORMATION

To facilitate the processing of your insurance claim, the following information is necessary. You may obtain this information by contacting your insurance company or your employer's personnel department.

Insurance Company Name:	Address:	City:	State:	Zip:
Phone: ()	Contact:	Lifetime Maximum Benefit:		
Payable at: %	Effective Date:	Pays: Monthly / Quarterly	Pays: Automatically /as billed	
Occupation:	Employer:			
Employer Address:			Employer Phone Number:	
Subscriber's name:			Subscriber's S.S.N.:	
Birth Date: / /	Group ID no.:	Group Name:		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Name of secondary insurance (if applicable):			Subscriber's name:	
Birth Date: / /	Group ID no.:	Group Name:		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

1. Patients with traditional orthodontic insurance are billed on 50% co-payment basis.
2. Insurance policies and payment programs can be confusing. We suggest that our patients contact their insurance companies to confirm that their assumptions regarding coverage for orthodontic treatment are correct. It is best to request this information in writing from your insurance company.

Our business coordinator will be happy to answer any questions in order to help clarify these policies.