

INSURANCE INFORMATION FORM

Primary Insurance

Date _____ No orthodontic coverage _____

Patient Name _____ DOB _____

Subscriber Name _____

Subscriber Address _____

Subscriber DOB _____ SSN _____ ID # _____

Subscriber relationship to patient _____

Insurance Carrier _____

Insurance Claims Filing Address _____

Phone _____ Group Number: _____

Employer Name _____

Effective Date of Coverage _____

List Secondary Information On Back of This Form

FOR OFFICE USE ONLY

Lifetime Max _____ Paid at % _____ Deductible _____

Age Limit _____% paid at banding _____ Waiting Period _____

Do you accept Electronic filing _____ Payor ID # _____

Auto Pay Monthly _____ Quarterly _____ Annually _____

Bill Monthly _____ Quarterly _____ Annually _____

Standard coordination of benefits _____

Secondary Insurance

Date _____ No orthodontic coverage _____

Patient Name _____ DOB _____

Subscriber Name _____

Subscriber Address _____

Subscriber DOB _____ SSN _____ ID # _____

Subscriber relationship to patient _____

Insurance Carrier _____

Insurance Claims Filing Address _____

Phone _____ Group Number: _____

Employer Name _____

Effective Date of Coverage _____

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