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 ______________________________________

A copy of your insurance card (front and back) is required

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 ____

A copy of your insurance card (front and back) is required
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_____________________________________