

ORTHODONTIC INSURANCE INFORMATION

Patient Name _____ Date of Birth ____/____/____

PRIMARY POLICYHOLDER INFORMATION

Name _____ ID # or SS # _____

Date of Birth ____/____/____ Relationship to Patient _____

Employer _____ 0 Hourly 0 Salary

Dental Ins Company _____ Ins Phone # _____

Ins Address _____ City _____ St _____ Zip _____

**** Note: Medical Insurance does not cover orthodontic treatment.**

FOR OFFICE USE ONLY

Lifetime Maximum - Orthodontics \$ _____ Deductible \$ _____ Age Limit _____

Benefits are paid @ _____% Amount used \$ _____ Effective Date: _____

Automatic Payments 0 YES 0 NO Payments 0 Monthly 0 Quarterly Group # _____

Date Verified/Initials _____

SECONDARY POLICYHOLDER INFORMATION

Name _____ ID # or SS # _____

Date of Birth ____/____/____ Relationship to Patient _____

Employer _____ 0 Hourly 0 Salary

Dental Ins Company _____ Ins Phone # _____

Ins Address _____ City _____ St _____ Zip _____

**** Note: Medical Insurance does not cover orthodontic treatment.**

FOR OFFICE USE ONLY

Lifetime Maximum - Orthodontics \$ _____ Deductible \$ _____ Age Limit _____

Benefits are paid @ _____% Amount used \$ _____ Effective Date: _____

Automatic Payments 0 YES 0 NO Payments 0 Monthly 0 Quarterly Group # _____

Date Verified/Initials _____

I authorize release of any information relating to this claim and I authorize payment directly, where applicable, to the office of Dr. Ginzler and Dr. Shaw. I do understand that the benefit information given here is not a guarantee of benefits.

Primary Policyholder's Signature

Date

Secondary Policyholder's Signature

Date