

# ORTHODONTIC INSURANCE INFORMATION

PATIENT NAME \_\_\_\_\_

**Appt. Date** \_\_\_ / \_\_\_ / \_\_\_ @ \_\_\_\_\_

**Date of Birth** \_\_\_ / \_\_\_ / \_\_\_

## PRIMARY POLICYHOLDER INFORMATION

Name \_\_\_\_\_ ID # or SS # \_\_\_\_\_

Date of Birth \_\_\_ / \_\_\_ / \_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_  Hourly  Salary

Dental Ins. Company \_\_\_\_\_ Ins. Phone # ( \_\_\_ ) \_\_\_ - \_\_\_\_\_

Ins. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ 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  Yes  No Payments  Monthly  Quarterly Group # \_\_\_\_\_

Date Verified/Initials \_\_\_\_\_ To:  Home  Office Payer ID # \_\_\_\_\_

## SECONDARY POLICYHOLDER INFORMATION

Name \_\_\_\_\_ ID # or SS # \_\_\_\_\_

Date of Birth \_\_\_ / \_\_\_ / \_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_  Hourly  Salary

Dental Ins. Company \_\_\_\_\_ Ins. Phone # ( \_\_\_ ) \_\_\_ - \_\_\_\_\_

Ins. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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