

Changing lives, improving self-confidence. Since 1965. Members American Association of Orthodontics.

ORTHODONTIC INSURANCE INFORMATION

(The information provided is strictly confidential. Please print legibly)

We will be happy to assist you in determining your orthodontic insurance benefits, however all information must be completed and signed by the insured party.

Patient's legal name: _____ Preferred name: _____
Birthdate: _____ Age: _____ Sex: M / F

PRIMARY INSURANCE

Name of insured: _____ Birthdate: _____
Home Address: _____ City, State, Zip: _____
Home phone: _____ Cell phone: _____
SS# of Insured: _____ Relationship to patient: _____

Employer: _____ Occupation: _____
Address: _____
City, State, Zip: _____ Telephone #: _____

Insurance company: _____ Group #: _____
Address: _____
City, State, Zip: _____ Telephone #: _____

I understand that upon my request you will file any charges incurred at your office with my insurance company, however there is no guarantees of coverage and I am ultimately responsible for the account.

I hereby authorize release of any information relating to this claim and authorize payment directly to Abdoney Orthodontics.

Signature of insured party for primary insurances

Today's date