

INSURANCE INFORMATION

PATIENT INFORMATION

1. Patient name: _____ Sex: **M** **F** Birthdate: ___/___/___
2. Patient name _____ Sex **M** **F** Birthdate: ___/___/___
3. Patient name _____ Sex **M** **F** Birthdate: ___/___/___
Self spouse child other
Relationship to policy holder: ___ ___ ___ ___

DENTAL INSURANCE INFORMATION

Insurance Company: _____ Group# _____
Address: _____ ID # _____
Phone #: _____
(Payor ID: _____ office use only)

POLICY HOLDER INFORMATION

Policy holder name: _____ Birthdate: ___/___/___
SS# _____
Employer name: _____
Address: _____
Is your address the same as patient's address **YES NO**
If **NO** please fill in below:
Address: _____

Is patient covered by another orthodontic insurance plan: **YES NO**
(if yes, please request another form.)

I authorize release of any information
relating to this claim.

I authorize payment directly to
Orthodontic Associates of the insurance
benefits otherwise payable to me.

PLEASE SIGN ON BOTH LINES

PATIENT OR PARENT IF MINOR

DATE

POLICY HOLDER

DATE

FOR OFFICE USE ONLY

% OF COVERAGE: _____

ORTHO MAX:\$ _____

ANY USED? YES \$ _____ NO

DEDUCTIBLE:\$ _____ MET THIS YEAR: YES NO

WAITING PERIOD YES NO

AGE RESTRICTIONS YES _____ NO

PAY FOR RECORDS? YES NO

PAY AUTOMATICALLY: YES NO