



## Insurance Information

### Primary Insurance

Orthodontic Coverage?

Yes     No  
 Male     Female

Patients Name: \_\_\_\_\_

Patients Birthdate \_\_\_/\_\_\_/\_\_\_

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group#(Plan, local, or policy) \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Address \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insured's Birthdate \_\_\_/\_\_\_/\_\_\_

Insured's Social Security# \_\_\_\_\_ (or ID #)

Insured's Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

### Secondary Insurance

Orthodontic Coverage?

Yes     No  
 Male     Female

Patients Name: \_\_\_\_\_

Patients Birthdate \_\_\_/\_\_\_/\_\_\_

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group#(Plan, local, or policy) \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Address \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insured's Birthdate \_\_\_/\_\_\_/\_\_\_

Insured's Social Security# \_\_\_\_\_ (or ID #)

Insured's Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_