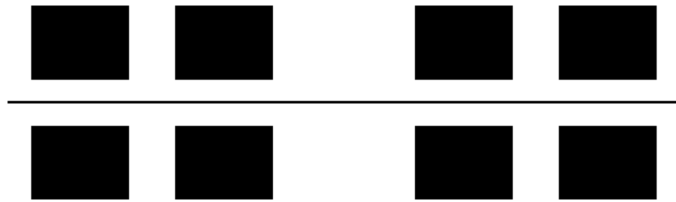

Insurance Information

Primary Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Patients Name:__________________________ ☐ Male ☐ Female

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

Patients Name:__________________________ ☐ Male ☐ Female

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____