

Insurance Information Sheet

Insurance Company Name and Address: _____

Insurance Co. Phone #: _____

Patient's Full Name: _____

Patient's relationship to insured: self ___ /spouse ___ /child ___ /other ___

Patient's Birthday: _____ / _____ / _____

Insured's Name and mailing address:

Insured's Birthdate:

_____ / _____ / _____

Insured's SSN# OR ID#: _____ - _____ - _____ **Group #** _____

Employer (company) and address: _____

Is Patient covered by another plan of benefits? Yes ___ No ___

- If yes, complete the following
- If no, skip remaining info and sign bottom.

Insurance Company Name and Address: _____

Insurance Co. Phone #: _____

Insured's Name and mailing address:

Insured's Birthdate:

_____ / _____ / _____

Patient's relationship to insured: self ___ /spouse ___ /child ___ /other ___

Insured's SSN# OR ID#: _____ - _____ - _____ **Group #** _____

Employer (company) and address: _____

I authorize the release of any information relating to orthodontic treatment.

X _____

I hereby authorize payment of the group insurance benefits otherwise payable to me, to be directly paid to the orthodontist.

X _____

Office Use Only

Insurance Code # _____

Date: _____

Name: _____

Coverage: _____

Effective Date: _____

Deductible: _____

What % of total for initial: _____

Any Used: _____

Bill: Monthly---Quarterly---Annual

Automatic Bill

CONTX # _____

Pre-auth required: yes no

Computer updated: yes no

Office Use Only

Insurance Code # _____

Date: _____

Name: _____

Coverage: _____

Effective Date: _____

Deductible: _____

What % of total for initial: _____

Any Used: _____

Bill: Monthly--Quarterly--Annual

Automatic Bill

CONTX # _____

Pre-auth required: yes no

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