INSURANCE INFORMATION

All patients/parents with dental or orthodontic insurance must fully complete this form. Incomplete information will result in delay of benefit determination. Orthodontic coverage is subject to specific limitation and exclusions according to your specific plan. **Please refer to your dental booklet or with your Human Resources Dept. for a description of orthodontic benefits, deductibles, maximum coverage, and age limitations.**

Patient Name: ____

Patient Birthdate: ____

Relationship to policy holder (circle one): self spouse dependent child

---

POLICYHOLDER INFORMATION:

Name: ______________________ Birthdate: ______________________

Mailing Address: ____

Social Security # ______________________ ID # ______________________

Employer: ______________________ Insurance Carrier: ______________________

Employer Address: Insurance Carrier's Mailing Address:

______________________ ______________________

______________________ ______________________

Group # ______________________ Ins. Carrier's Phone #: ______________________

WHAT IS YOUR MAXIMUM ORTHODONTIC INSURANCE COVERAGE: $ ______________

Is patient covered by any other dental plan? (circle one): Yes No If yes: Please complete additional form.

I hereby certify that the above information is correct:

XX ______________________ __________
Policyholder/Employee Signature date

I authorize the release of any information relating to my orthodontic insurance claim:

XX ______________________ __________
Patient (Parent, if minor) date

I AM PERSONALLY RESPONSIBLE FOR ANY BALANCE NOT PAID BY INSURANCE.

ASSIGNMENT OF BENEFITS: SIGN ONLY ONE OF THE LINES BELOW:

I hereby authorize payment directly to the attending dentist.

XX ______________________ __________
Policyholder/Employee Signature date

Patient has paid attending dentist in full. I hereby direct benefits payable to the insured.

______________________ __________
Policyholder/Employee Signature date