Dental Insurance Information Form

This form is for DENTAL coverage only. The information you provide will be used to verify your orthodontic benefit, so please fill out this form completely. As a courtesy, we are happy to file an insurance claim on your behalf once active treatment is initiated. Without this information we are unable to file your claim.

Patient Name: ____ Patient's DOB: _________________

Primary Insurance Co Name: ______________________________________ Phone # ______________

Insurance Co. Address: ____________________________________City ________State _____ Zip _____

Subscriber's Full Name: _________________________Relationship to Patient:__________ DOB: _______

Subscriber's Address: ____________________________________City _________State____ Zip_______

Social Security # ________________Subscriber ID # ____________________________Group #_________

Employer: ____ Work Phone # _________________

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Secondary Insurance Co Name: ______________________________________ Phone # _____________

Insurance Co. Address: ____________________________________City ________State _____ Zip _____

Subscriber's Full Name: _________________________Relationship to Patient:__________ DOB: _______

Subscriber's Address: ____________________________________City _________State____ Zip_______

Social Security # ________________Subscriber ID # ____________________________Group #_________

Employer: ____ Work Phone # _________________

*******OFFICE USE *******

Ins. Co. ____________________________ Date of Call ___________ Name of Representative ________________
Effective Date ___________________________ Waiting Period ________ Deductible ______ Age Limit ______
Lifetime Benefit ______________________________ Has Any Benefit Been Used? ________________________
Benefit Paid? Monthly – Quarterly – Annually – Other ______ Automatic? Yes or No
Benefit Coordination (if two): Standard or Non Duplication Does Birthday Rule Apply? Yes or No
Benefit Paid to: Subscriber or Provider

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Banding Date: ________Procedure: __________Treatment Fee: ________Months of Tx:_______