

 **Orthodontic Insurance Information**

Insurance Company Information

Name Address (City, State, Zip) Phone

Group Number

Patient Information

Name

Date of Birth Is patient a full time student?

Age

Sex: Male

Female\_

Relationship to Insurance Subscriber (employee):

Self

Spouse

Child

Other

Employee/Subscriber Name Address\_ (City, State, Zip) Social Security Number\_ Patient ID Number

Employer (company) Name Address\_ (City, State, Zip)

Is patient covered by another dental plan?

If yes, Please provide:

Employee/Subscriber Name Social Security Number\_ Patient ID Number

Employer (company) Name Address\_ (City, State, Zip)

I authorize the release of any information relating to this claim:

Signature (patient, or parent) Date I hereby authorize payment directly to Family Orthodontics:

Signature (Insured Person) Date

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