Orthodontic Insurance Information

Insurance Company Information
Name____________________________________
Address__________________________________
(City, State, Zip)___________________________
Phone____________________________________ Group Number_________________

Patient Information
Name____
Date of Birth___________________Is Age______ Sex: Male_____ Female_____
patient a full time student? __________
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

388 Park Avenue – Worcester, MA 01610 • Phone: (508) 798-6565 • Fax: (508) 798-6687