INSURANCE INFORMATION

In accordance with state and federal laws, and to protect your privacy, please complete the following insurance information in order for us to verify any orthodontic benefits available to you. Please note that this information may not be readily available upon our request, therefore it may be necessary for us to get back with you at a later time.

- ☐ **I DO NOT HAVE DENTAL INSURANCE THAT COVERS ORTHODONTIC CARE**
- ☐ **I BELIEVE THAT I HAVE DENTAL INSURANCE THAT COVERS ORTHODONTIC CARE**

PRIMARY DENTAL INSURANCE INFORMATION:

NAME OF SUBSCRIBER

SUBSCRIBERS DATE OF BIRTH:

SOCIAL SECURITY NUMBER/ID #

NAME OF INSURANCE COMPANY:

ADDRESS OF INSURANCE COMPANY:

Text Field State: ZIP:

Text Field Text Field

PRIMARY DENTAL INSURANCE INFORMATION:

NAME OF SUBSCRIBER

SUBSCRIBERS DATE OF BIRTH:

SOCIAL SECURITY NUMBER/ID #

NAME OF INSURANCE COMPANY:

ADDRESS OF INSURANCE COMPANY:

Text Field State: ZIP:

Text Field Text Field

IF ORTHODONTIC INSURANCE COVERS ALL OR PART OF THE CASE FEE, IT MAY BE PAID DIRECTLY TO OUR PRACTICE OR TO THE POLICY HOLDER AS AGREED BY EACH PARTY. THE FINANCIALLY RESPONSIBLE PARTY MUST PAY WHATEVERPART OF THE ACCOUNT BALANCE NOT PAID DIRECTLY TO THE PRACTICE BY THE INSURANCE COMPANY. IF THE INSURANCE COMPANY FAILS TO PAY BENEFITS TO OUR PRACTICE WITHIN 90 DAYS, THE FINANCIALLY RESPONSIBLE PARTY WILL BE INFORMED BY OUR OFFICE. AT THAT TIME THE UNPAID INSURANCE BALANCE WILL BE TRANSFERRED TO THE PATIENT. WE WILL ADJUST YOUR MONTHLY PAYMENT PLAN TO REFLECT UNPAID BENEFITS.

Signature Today's Date:

Print Form