

# ORTHODONTIC INSURANCE INFORMATION

Consult Date \_\_\_\_\_

We are very happy to file your insurance however, we need **complete** information, or there maybe a delay in receiving your insurance benefits.

<b>PATIENT'S NAME</b>	<b>RELATIONSHIP TO THE INSURED</b>	<b>SEX</b>	<b>PATIENT'S BIRTHDAY</b>	If you have a 2nd insurance in effect at the time of your consult, and it is not presented at that time; it may result in a contract change (higher or lower) which could result in a change of your monthly payment.
First      MI      Last	Self    Child	M	Mo.   Day   Yr.	
Phone #	Spouse   Other	F		

<b>NAME &amp; ADDRESS OF THE EMPLOYED PERSON</b>	<b>S.S.# OF THE EMPLOYED</b>	<b>THE EMPLOYED WORKS FOR:</b>
		Co.
	<b>BIRTHDAY</b>	City
	Mo.   Day   Yr.	Phone #

<b>NAME OF THE INSURANCE COMPANY</b>	<b>THE 800 PHONE # OF THE INS. CO.</b>	<b>GROUP # OF INSURANCE POLICY</b>
<b>ADDRESS OF INSURANCE CO.</b> <small>Mailing Address</small>	<b>THE DATE YOUR INS. WENT INTO EFFECT.</b>	<b>IS THERE A WAITING PERIOD FOR ORTHO?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
	<b>* Do have a 2<sup>nd</sup> insurance?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>WHAT IS THE LIFETIME MAXIMUM ORTHO BENEFITS?</b>
<b>If you are an adult, do you have adult ortho Insurance?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Do You Have Another Family Member In Treatment With Us?</b>	<b>INS. WILL PAY?</b>
<b>Do you need a referral from your Primary Dentist?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>INS. IS PAID AT WHAT PERCENT?</b>
		<b>HAVE YOU USED ANY OF YOUR ORTHO BENEFITS?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO

IS THERE A WAITING PERIOD FOR ORTHO?    YES    NO

Consult \_\_\_\_\_      Ded \_\_\_\_\_      Pre-existing \_\_\_\_\_  
 Banding \_\_\_\_\_      Pay's — M — Q — Auto \_\_\_\_\_      Used \_\_\_\_\_  
 Extractions included in ortho max \_\_\_\_\_      Age Limits \_\_\_\_\_