INSURANCE INFORMATION FORM

Please fill out form completely

Make sure you have the Policy holders Name, Date of Birth, and SS# before you call your insurance company.

Patient Name:_____Date of Birth:_____

Policyholders Name:_____Date of Birth:_____

Insurance Company Name:_____

Insurance Company Address:_____

Insurance Company Phone Number:_____

Subscriber ID#:_____ Group #:_____

Lifetime Orthodontic Maximum: $_____ Deductible: $_____

Payable at what Percent:_____ Waiting Period:_____

Age Limit & Adult Coverage:_____

Payouts:

Please Circle One

AUTOMATIC MONTHLY QUARTERLY SIX MONTHS

Signature:_____Date:_____