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: *To be verified by our office staff*

Name of Subscriber: ______________________________

Subscriber's Date of Birth: ______________________________

Social Security Number: ______________________________

Name of Insurance Company: ______________________________

Address of Insurance Company: ______________________________

City: ____________________ State: _________ Zip: ________________

Phone Number of Insurance Company: ______________ Effective Date: ________

Identification #: ____________ Group #: ____________ Plan Code: ______________

Secondary Dental Insurance Information: *To be verified by our office staff*

Name of Subscriber: ______________________________

Subscriber's Date of Birth: ______________________________

Social Security Number: ______________________________

Name of Insurance Company: ______________________________

Address of Insurance Company: ______________________________

City: ____________________ State: _________ Zip: ________________

Phone Number of Insurance Company: ______________ Effective Date: ________

Identification #: ____________ Group #: ____________ Plan Code: ______________

☐ ***I have a flexible healthcare spending account. Please give us the details related to your orthodontic coverage.***

IF ORTHODONTIC INSURANCE covers all or part of the case fee; it may be paid directly to our practice or to the policyholder as agreed by each party. The **FINANCIALLY RESPONSIBLE PARTY (Guarantor)** must pay whatever part 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 your ledger. We will adjust your monthly payment plan to reflect unpaid benefits.

Patient (or Guardian's)
Signature____ Date________________