INSURANCE INFORMATION

PATIENT NAME _____

PATIENT DATE OF BIRTH _____

RESPONSIBLE PARTY NAME (PRINTED) _____

POLICY HOLDER NAME (PRINTED) _____

POLICY HOLDER ADDRESS _____

_____

POLICY HOLDER BIRTH DATE (PRINTED) _____

SOCIAL SECURITY NUMBER _____ ID # _____

INSURANCE COMPANY _____

(PRIMARY/SECONDARY – NAME/ADDRESS/PHONE)

_____

VERIFIED LIFETIME ORTHODONTIC MAX $_____ PAYABLE AT _____ %

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

I also hereby authorize payment of the dental benefits otherwise payable to me directly to Northeast Orthodontic Specialists.

Signed _____ Policy Holder

Date_____

The practice will file your insurance claims as a courtesy to you. We must have current accurate insurance information for you to receive a benefit. In the event that you have a change of insurance, promptly complete a new form. A copy of this form and any updated forms will be given to you, which you should retain for your records.

***If for any reason the estimated amount is not paid by your insurance company it becomes your obligation.*

Form updated 11/5/2010