OTAY LAKES ORTHODONTICS

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ORTHODONTIC INSURANCE INFORMATION

DATE ____ / ____ / ____

In order to assist you in receiving the greatest benefit from your orthodontic insurance, it will be helpful to have the following information completed.

Patient Name _____ Date of Birth ___ / ___ / ___ Relationship to insured _____

Insured Name _____ Date of Birth ___ / ___ / ___ Social Security # _____

Employer _____

Address _____

Insurance Co. _____ Policy or Group # _____

Insurance Co. Address _____

Insurance Co. Telephone (800 # if available) _____

If the patient is covered by a second insurance policy; please complete the following information for the second insurance policy.

Insured Name _____ Date of Birth ___ / ___ / ___ Social Security # _____

Patient relationship to the insured _____

Employer _____

Address _____

Insurance Co. _____ Policy or Group # _____

Insurance Co. Address _____

Insurance Co. Telephone (800 # if available) _____

If the patient is covered by a third insurance policy, please complete the following information for the third insurance policy.

Insured Name _____ Date of Birth ___ / ___ / ___ Social Security # _____

Patient relationship to the insured _____

Employer _____

Address _____

Insurance Co. _____ Policy or Group # _____

Insurance Co. Address _____

Insurance Co. Telephone (800 # if available) _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

Signature (Patient or Parent of minor) _____ Date ____ / ____ / ____