

PATIENT INSURANCE INFORMATION FORM

Patient Name: \_\_\_\_\_  
Full Time Student School (if 19 or over) \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber Address: \_\_\_\_\_

Subscriber Soc. Sec. # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance ID # \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_ Tel: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Group Dental Plan: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Group #: \_\_\_\_\_ Location: (if applicable) \_\_\_\_\_

Is Patient Covered By Another Plan? If so:

Subscriber Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Subscriber Address: \_\_\_\_\_

Subscriber Soc. Sec. # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance Co. Name: \_\_\_\_\_ Tel. # \_\_\_\_\_

Address: \_\_\_\_\_

Name of Group Dental Plan: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_

Group #: \_\_\_\_\_ Location \_\_\_\_\_

**I authorize release of any information relating to this claim. I agree that I am responsible for all costs of orthodontic treatment not covered by my insurance.**

\_\_\_\_\_  
Signature

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Procedure Code:

Description of Treatment: