

PATIENT DENTAL 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. Insurance coverage is only an estimate. Should the actual figure differ, the balance will be assumed by the responsible party. If your insurance carrier or policy changes it is your responsibility to notify AOC or the unpaid balance will be transferred to the billing party.

Signature

I give permission to AOC to speak to my parents/guardian regarding my treatment and financials.

Parents/Guardian name(s): _____, _____

Signature: _____

Date: _____