2470 Daniells Bridge Road, Suite 201
Athens, Georgia 30606
706.353.3500

ORTHODONTIC INSURANCE INFORMATION

In order to assist you in determining your orthodontic insurance benefits, the following information is needed. Completing this information and bringing it to your first appointment saves you considerable time.

Name of Patient ____ Date of Birth __________________

Name of Insured ____ Date of Birth __________________

Mailing Address ____

Social Security # ____ Phone_______________________

Employer ____ Phone ______________________

Address____

Insurance Company ____ Policy/Group # _______________

Address of Ins. Co. ____

Ins. Co. Phone____

IS PATIENT COVERED UNDER A 2nd DENTAL PLAN? IF SO, PLEASE COMPLETE THE BELOW INFORMATION:

Name of Patient ____ Date of Birth __________________

Name of Insured ____ Date of Birth __________________

Mailing Address ____

Social Security # ____ Phone_______________________

Employer ____ Phone ______________________

Address____

Insurance Company ____ Policy/Group # _______________

Address of Ins. Co. ____

Ins. Co. Phone____

/s____ Date __________________________________
signature

I hereby authorize release of any information relating to this claim.

/s____ Date __________________________________
signature

Please notify our office of any changes in your insurance policy as soon as possible.