SIGNATURE ON FILE

Please fill out this form for group or private dental insurance. Completing all information allows us to help you receive your maximum insurance benefits.

PATIENT NAME____ Birth Date______________________

PRIMARY ORTHODONTIC INSURANCE

Subscribers Name____ Birth Date______________________

Street Address____ SS#__________________________

City, State, Zip____ Relationship to Patient ____________

Employer____

Insurance Company Name____

Insurance Address and Phone____

ID #____ Group #______________________

SECONDARY ORTHODONTIC INSURANCE

Subscribers Name____ Birth Date______________________

Street Address____ SS#__________________________

City, State, Zip____ Relationship to Patient____________

Employer____

Insurance Company____

Insurance Address and Phone ____

ID #____ Group #______________________

COORDINATION OF BENEFITS INFORMATION: If a patient is eligible for coverage under two or more orthodontic care programs, the primary insurance is determined by the birthdate of the subscribers unless designated by divorce decree or guardianship papers.

The undersigned, hereby authorizes the release of any information relating to all claims for benefits on behalf of the above named dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims or benefits, for services rendered without obtaining my signature on each and every claim for my dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I understand that it is my responsibility to inform the dental office of any changes which affect the above information.

Signature____ Date____________________