niepraschk ORTHODONTICS

Patient Name _____ Date of Birth _____/_____/_____

INSURANCE INFORMATION/RELEASE AUTHORIZATION

*Please note: We Must have a Social Security Number to Verify and/or Bill Insurance

PRIMARY INSURED

Insured's Name: _____ Date of Birth _____/_____/_____

Address: _____ Social Security #: _____-_____-_____

City, State, Zip: _____ Member ID #: _____

Employer _____ Group/Contract #: _____

Name of Insurance Company _____

Mail Claims to: _____

Insurance Company Phone #: (_____) _____-_____

Do you have DENTAL Insurance? _____ Do you have ORTHO Insurance?_____

Office Use

Effective Date: _____ _____% of Initial Down Payment

Lifetime Ortho Max: $_____ _____% ( ) Monthly ( ) Semi- Annually

Amount Used: $_____ ( ) Quarterly ( ) Annually

Amount Remaining: $ _____ Deductible: $ _____ annually

Age Limit: _____ Work in Progress: ( ) Yes ( ) No

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed for this particular claim.

_____

Authorized Signature of Covered Person/Employee **Date**