

IN ORDER TO PROPERLY FILE FOR ORTHODONTIC BENEFITS, WE REQUIRE THE FOLLOWING INFORMATION:
(If any part of the insurance balance is not paid, it does remain the patient's responsibility)

NAME OF PATIENT: _____ **DATE OF BIRTH:** _____

PRIMARY DENTAL COVERAGE

PLACE OF EMPLOYMENT OF INSURED: _____

ADDRESS OF EMPLOYER: _____

EMPLOYER'S TELEPHONE NUMBER: _____

PRIMARY INSURED'S NAME: _____

PRIMARY INSURED'S BIRTHDATE: _____ **SOCIAL SECURITY #:** _____

PATIENT'S RELATIONSHIP TO INSURED: _____

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

TELEPHONE NUMBER: _____ **ID #:** _____

****ADDR/GRP# VERIFIED** _____

SECONDARY DENTAL COVERAGE

PLACE OF EMPLOYMENT OF INSURED: _____

ADDRESS OF EMPLOYER: _____

EMPLOYER'S TELEPHONE NUMBER: _____

SECONDARY INSURED'S NAME: _____

SECONDARY INSURED'S BIRTHDATE: _____ **SOCIAL SECURITY #:** _____

PATIENT'S RELATIONSHIP TO INSURED: _____

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

TELEPHONE NUMBER: _____ **GROUP #:** _____

****ADDR/GRP# VERIFIED** _____

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

SIGNATURE: _____ **DATE:** _____

I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO PAQUETTE ORTHODONTICS.

SIGNATURE: _____ **DATE:** _____

FOR OFFICE USE ONLY

Ortho Coverage? Yes _____ No _____ Lifetime Maximum _____ Payable @ _____ % Deductible _____

Effective Date _____ Lifetime Maximum Met _____ Age Limit _____ Deductible Met _____

Monthly _____ Quarterly _____ Auto _____ As Filed _____ Payable on Fee Schedule _____ Initial _____ Balance _____

Pay Provider _____ VERIFIED BY _____ DATE _____ Spoke with _____