Embrace Our World
ORTHODONTICS
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DENTAL INSURANCE INFORMATION

The following information is essential to verify your benefits:

Patient's Name: _____ Date of Birth: _____

Policyholder's Name: _____ Date of Birth: _____

Policyholder's Address: _____

_____

Policyholder's Telephone: _____

Policyholder's Social Security # or Insurance ID: _____

Policyholder's Employer: _____

DENTAL Insurance Company: _____ (No medical policies, please.)

Address of Insurance Company: _____

_____

Group Number: _____

Insurance Company Telephone: _____

Is patient covered under another dental plan? If so, please inform our Front Desk.

I hereby authorize payment of insurance benefits directly to the below named orthodontist .

_____ Date _____
Signature

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

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