

# INSURANCE INFORMATION

All patients with dental or orthodontic insurance (which may provide benefits to be used as partial payment for orthodontic services rendered) need to complete this form as fully as possible. Any information which you are unsure of may be phoned in to our office. Incomplete information will result in delay of benefit determination. Orthodontic coverage is subject to specific limitations and exclusions according to your specific insurance plan, please refer to your dental booklet for a description of covered expenses, deductibles, maximums, and copayment information. Most insurance carriers prefer initial claims to be entered with their company form, you will need to obtain this from your employer, fill out the patient parts of the form, and provide it to our office before benefits can be estimated or claims submitted.

*At this time, our office does not charge fees for filing pre-treatment estimates, filing or handling claims, separate insurance accounting, or monthly insurance maintenance.*

Patient Name: \_\_\_\_\_  
last
first
middle
nickname

Patient Birthdate: \_\_\_\_\_

Relationship to policy holder (circle one): self spouse dependent child other \_\_\_\_\_

\*\*\*\*\*  
 POLICYHOLDER:

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_ Insurance Carrier's Claims Mailing Address: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Policy or Group #: \_\_\_\_\_

Employer's Phone #: \_\_\_\_\_ Insurance Carrier's Phone (if available) \_\_\_\_\_

Employer's Ins. Contact Person: \_\_\_\_\_

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 Is patient covered by any other dental plan (circle one): Yes No If yes: Please complete additional form for second insurance.

I hereby certify that the above information is correct: \_\_\_\_\_ I authorize the release of any information relating to my orthodontic insurance claim: \_\_\_\_\_

**XX** \_\_\_\_\_ **XX** \_\_\_\_\_  
 Policyholder/Employee Signature date Patient (Parent, if minor) Signature date

**I AM PERSONALLY RESPONSIBLE FOR ANY BALANCE NOT PAID BY INSURANCE**

**ASSIGNMENT OF BENEFITS:** (Please sign only ONE of the below; benefits payable to attending dentist OR insured)

I hereby authorize payment directly to the attending dentist  _____ Policyholder/Employee Signature date	Patient has paid attending dentist in full for services rendered. I hereby direct benefits payable to the insured;  _____ Policyholder/Employee Signature date
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**“ B R A Y C E S “**