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 ______________