

PATIENT INFORMATION

Last Name		First Name		Nickname		SS NO.		Sex	Birthdate	Age
Mailing Address		City			State	Zip		School (if student)		
#	Home Phone	Business Phone		Cell Phone # and Provider (for text reminders)			Fax			
Email (for email reminders)				Name of Dentist			Date of last visit			
Related patients that are or have been under our care				Names and Ages of other children						

PARENT/ BILLING PARTY INFORMATION (please complete if patient is a minor)

PRIMARY NAME _____ ADDRESS _____ CITY _____ ST _____ ZIP _____ CELL # _____ WORK # _____ DOB ____/____/____ SS#. _____ - _____ - _____ EMAIL _____ EMPLOYER _____ ADDRESS _____ CITY _____ ST _____ ZIP _____ INSURANCE CO: _____ GROUP # _____ POLICY ID: _____ INSURANCE CLAIMS ADDRESS: _____ INSURANCE TELEPHONE# _____	SECONDARY NAME _____ ADDRESS _____ CITY _____ ST _____ ZIP _____ CELL # _____ WORK # _____ DOB ____/____/____ SS#. _____ - _____ - _____ EMAIL _____ EMPLOYER _____ ADDRESS _____ CITY _____ ST _____ ZIP _____ INSURANCE CO: _____ GROUP # _____ POLICY ID: _____ INSURANCE CLAIMS ADDRESS: _____ INSURANCE TELEPHONE #: _____
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PLEASE NOTIFY OUR OFFICE OF ANY CHANGES IN YOUR INSURANCE CARRIER AS SOON AS POSSIBLE.

INSURANCE PAYMENTS

The majority of insurance policies pay only a percent of the orthodontic fee based on your employer's contract with them. Ultimately, what your insurance carrier pays is between you, the carrier and the contract between your employer and the insurance carrier.

Upon presentation of your insurance card, we attempt to obtain a verbal description of coverage prior to claim submission. Verbal confirmation however does not guarantee payment. Benefit determination can be made only when a claim is submitted payable subject to your plan provisions and the coordination of benefits with other group plans when applicable.

AUTHORIZATION STATEMENT

I authorize the release of information necessary to process any claim for services provided by this establishment, and payment of benefits directly to this office. A copy of this authorization may be used in place of the original. I understand that I am responsible for any balances not covered by insurance.

Patients/Parents or members are responsible for notifying this office of any changes in orthodontic coverage, policy status, or change of carrier/administrator.

Name of Policyholder: _____

Signature: _____

Date: _____

WE ARE UNABLE TO ACCEPT DIVORCE DECREES AS ASSIGNMENTS OF RESPONSIBILITY FOR A CHILD'S ORTHODONTIC BILLS. THE PARENT ACCOMPANYING THE CHILD SHOULD PAY FOR THE SERVICES AND SEND ANY REIMBURSEMENT FOR THE OTHER PARENT. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I GIVE MY PERMISSION FOR ANY PHOTOGRAPHS, X-RAYS, OR STUDY MODELS TO BE USED FOR THE DISPLAYS AT SCIENTIFIC MEETINGS, PRESENTATION, AND PUBLICATION OF A SCIENTIFIC NATURE OR FOR STUDY GROUP PURPOSES TO FURTHER THE ART AND SCIENCE OF ORTHODONTICS. I, THE UNDERSIGNED, AGREE TO PAY FOR ATTORNEY FEES AND THEIR COSTS OF COLLECTIONS IN THE EVENT IT BECOMES NECESSARY TO USE ATTORNEY SERVICES TO SECURE PAYMENT OF THIS ACCOUNT.

Signature: _____

Date: _____