ORTHODONTIC INSURANCE FORM

In order to assist you in verifying your orthodontic insurance benefit, the following information *MUST* be filled out *COMPLETELY*:

PATIENT NAME_____ Date of Birth_____

Name of Policy Holder_____ Date of Birth_____

Address_____ Home phone_____

Social Security #_____ Alternate ID#_____

We MUST have your SSN or Alternate ID # to verify insurance. The insurance company will not provide us with benefits without it.

Employed by_____ Address_____

Insurance Company_____ Policy/Group#_____

Address of Insurance Company_____

Insurance Company Phone #_____

Is patient covered under another dental plan? If so, please complete the following information:

Name of Policy Holder_____ Date of Birth_____

Address_____ Home phone_____

Social Security #_____ Alternate ID#_____

We MUST have your SSN or Alternate ID # to verify insurance. The insurance company will not provide us with benefits without it.

Employed by_____ Address_____

Insurance Company_____ Policy/Group#_____

Address of Insurance Company_____

Insurance Company Phone #_____

I hereby authorize release of any information relating to this claim.

_____ _____

Signature Date

I hereby authorize payment of the insurance benefits directly to the above named orthodontists.

_____

Signature

Brenn Orthodontics
1400 W Olive Ave. Suite 101
Burbank, CA 91506
Phone: (818) 563-3825