INSURANCE INFORMATION FORM

SUBSCRIBER LAST NAME:________________________FIRST NAME:_________________________

TITLE:_________MIDDLE NAME:__________________RELATION TO PATIENT:________________

HOME ADDRESS:________________________________CITY:____________________STATE:______

HOME PHONE:__________________WORK PHONE:__________________SS NO.:________________

DOB:_____/_____/_____ MARITAL STATUS:_______________________SEX:___________________

PRIMARY INSURANCE COVERAGE

EMPLOYER NAME:____

ADDRESS:_______________________________________CITY:____________________STATE:______

INSURANCE COMPANY NAME:____

ADDRESS:_______________________________________CITY:____________________STATE:______

INSURANCE PHONE:_____________________________

GROUP NO.:____________POLICY HOLDER ID:____

ORTHODONTIC COVERAGE? YES NO MAXIMUM LIFETIME COVERAGE:________________

SECONDARY INSURANCE COVERAGE

EMPLOYER NAME:____

ADDRESS:_______________________________________CITY:____________________STATE:______

INSURANCE COMPANY NAME:____

ADDRESS:_______________________________________CITY:____________________STATE:______

INSURANCE PHONE:_____________________________

GROUP NO.:____________POLICY HOLDER ID:____

ORTHODONTIC COVERAGE? YES NO MAXIMUM LIFETIME COVERAGE:________________

RESPONSIBLE PARTY FOR PATIENT

NAME:____

SIGNATURE:____DATE:_________________