ORTHODONTIC INSURANCE INFORMATION

Appt. Date _____ at _____

PATIENT NAME _____ ***Date of Birth*** _____

PRIMARY POLICYHOLDER INFORMATION

Name _____ ID # or SS # _____
Policyholders Name — ID# is not the same as group # • BCBS accepts ID# ONLY. • INS cards without ID# use SS#

Date of birth _____ Relationship to Patient _____

Employer _____ ☐ Hourly ☐ Salary

Dental Ins. Company _____ Ins. Phone # _____

Ins. Address _____ City _____ State _____ Zip _____

**** Note: Medical Insurance does not cover orthodontic treatment***

FOR OFFICE USE ONLY

Lifetime Maximum - Orthodontics $ _____ Deductible $ _____ Age Limit _____ Benefits are paid @ %

Amount used $ _____ Effective Date: _____ Automatic Payments ☐ Yes ☐ No To: ☐ Home ☐ Office

Payments ☐ Monthly ☐ Quarterly Group # _____ Date Verified/Initials Payer ID # _____

SECONDARY POLICYHOLDER INFORMATION

Name _____ ID # or SS # _____
Policyholders Name — ID# is not the same as group # • BCBS accepts ID# ONLY. • INS cards without ID# use SS#

Date of birth _____ Relationship to Patient _____

Employer _____ ☐ Hourly ☐ Salary

Dental Ins. Company _____ Ins. Phone # _____

Ins. Address _____ City _____ State _____ Zip _____

**** Note: Medical Insurance does not cover orthodontic treatment***

FOR OFFICE USE ONLY

Lifetime Maximum - Orthodontics $ _____ Deductible $ _____ Age Limit _____ Benefits are paid @ %

Amount used $ _____ Effective Date: _____ Automatic Payments ☐ Yes ☐ No To: ☐ Home ☐ Office

Payments ☐ Monthly ☐ Quarterly Group # _____ Date Verified/Initials Payer ID # _____