Orthodontists Associates of WNY

Orthodontic Insurance Information

Patient's Name: _____ D.O.B. _____

Policy Holder: _____D.O.B._____Relationship:_____

Address : _____City: _____ State: ____ Zip: _____

Policy Holders Social Security Number: _____ Telephone: _____

Employer: _____ ID# _____Group# _____

Insurance Company: _____Telephone: _____

Claims Mailing Address: _____

IS PATIENT COVERED UNDER ANOTHER DENTAL PLAN? IF SO, COMPLETE THE FOLLOWING:

Policy Holder: _____D.O.B._____ Relationship:_____

Address: _____ City: _____ State: _____Zip: _____

Policy Holders Social Security Number: _____ Telephone: _____

Employer: _____ ID#_____ Group# _____

Insurance Company: _____ Telephone: _____

Claims Mailing Address: _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

X_____ _____
SIGNED (PATIENT OR PARENT, IF MONOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS ALLOWABLE UNDER MY DENTAL PLAN.

X_____ _____
SIGNED (PATIENT OR PARENT, IF MINOR) DATE

Life Time Max : P _____S_____
% Paid Out: P_____S_____
Deductable: P _____ S_____
Age Limitation: P_____S_____

Effective Date:P _____S_____
Waiting Period: P_____S _____
Benefit Used to Date: P_____S_____
Coordination of Benefits:P _____S_____