Orthodontic Insurance Information

Patient Name _____ Date of Birth _____

Appointment Date and Time _____

Please Note: Medical Insurance does not cover orthodontic treatment

Primary Policyholder Information

Name _____ ID# or SS# _____
Policyholder's name (ID# is not the same as group#. BCBS accepts ID# ONLY. INS cards without ID#s use SS#)

Date of Birth _____ Relationship to Patient _____

Employer _____ ☐ Hourly ☐ Salary

Dental Insurance Company _____ Insurance Phone # _____

Ins. Address _____ City _____ State _____ Zip _____

For Office Use Only:

Lifetime Maximum _____ Deductible _____ Age Limit _____ Benefits Paid at _____%

Amount Used _____ Effective Date _____ Group # _____ Payer ID# _____

Automatic Payments? Yes No **To:** Home Office **Payments Are:** Monthly Quarterly **Verification Initials:** _____

Secondary Policyholder Information

Name _____ ID# or SS# _____
Policyholder's name (ID# is not the same as group#. BCBS accepts ID# ONLY. INS cards without ID#s use SS#)

Date of Birth _____ Relationship to Patient _____

Employer _____ ☐ Hourly ☐ Salary

Dental Insurance Company _____ Insurance Phone # _____

Ins. Address _____ City _____ State _____ Zip _____

For Office Use Only:

Lifetime Maximum _____ Deductible _____ Age Limit _____ Benefits Paid at _____%

Amount Used _____ Effective Date _____ Group # _____ Payer ID# _____

Automatic Payments? Yes No **To:** Home Office **Payments Are:** _____ **Coordination of Benefits:** _____