Patient #_____ Entered in OPM_____

ORTHODONTIC INSURANCE INFORMATION

We must have the following information and a copy of your insurance card.

Patient Name:_____ **Birthdate:**_____

Policy Holder:_____ Relationship:_____ **Birthdate:**_____

Address:_____ City_____ State_____ Zip_____

Policy Holder's Social Security Number:_____ **Telephone:**_____

Employer:_____ ID#_____ **Group#/pkg #:**_____

Insurance Company:_____ **Telephone:**_____

Claims Mailing Address:_____

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

Policy Holder:_____ Relationship:_____ **Birthdate:**_____

Address:_____ City_____ State_____ Zip_____

Policy Holder's Social Security Number:_____ **Telephone:**_____

Employer:_____ ID#_____ **Group#/pkg #:**_____

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.

_____
SIGNED (PATIENT OR PARENT, IF MINOR) DATE

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

_____
SIGNED (PATIENT OR PARENT, IF MINOR) DATE

OFFICE USE ONLY

Circle ALL that apply:

	Trad tx cost	Invisalign cost
TX Fee:	$_____	$_____
Rec's Fee:	$_____	$_____
2% MN Tax:	$_____	$_____
Adjustment:	$_____	$_____
Total Cost:	$_____	$_____
Special Appl/service:	$_____	$_____

Rec's Date:_____ Est tx time_____ Class_____

PRELIMINARY: W-arch *Quad *Hyrax
Thumbcrib * H/G * Bionator * 2x4
Space maintainer (upper or lower)
FULL: Upper only * Lower only
Invisalign * Transfer In
RETAINER: Upper *Lower * /3-3
Replacement retainer * Repair

Insurance #1 **PPO___DMO___OTHER___**

Date_____ Spoke With:_____ Effective Date:_____ Age Limit:_____ Waiting Period_____

Group #:_____ Benefit:_____**% Lifetime$**_____**or Annual $**_____ **Benefit used $**_____

Accessing a Network through:_____

CLAIMS MAILING ADDRESS VERFIED:_____

Insurance #2 **PPO___DMO___OTHER___**

Date_____ Spoke With:_____ Effective Date:_____ Age Limit:_____ Waiting Period_____

Group #:_____ Benefit:_____**% Lifetime$**_____**or Annual $**_____ **Benefit used $**_____

Accessing a Network through:_____

CLAIMS MAILING ADDRESS VERFIED:_____