



# BURROW & CASE ORTHODONTICS

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DIPLOMATES AMERICAN BOARD OF ORTHODONTICS

## ORTHODONTIC INSURANCE INFORMATION

In order to assist you in determining your orthodontic insurance benefit, the following information is necessary:

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Telephone: \_\_\_\_\_

Employed by: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_

Insurance Company Telephone: \_\_\_\_\_

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

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Telephone: \_\_\_\_\_

Employed by: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy/Group#: \_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_

Insurance Company Telephone: \_\_\_\_\_

I hereby authorize release of any information relating to this claim.

\_\_\_\_\_  
Signature Date: \_\_\_\_\_

I hereby authorize payment of insurance benefits directly to the above named orthodontist.

\_\_\_\_\_  
Signature Date: \_\_\_\_\_

*Please notify our office of any changes in your insurance policy as soon as possible.*