

NEW PATIENT INSURANCE CLAIM FORM

Please fill out this form to your full knowledge. All information is needed to process your orthodontic claim.

1. PATIENT INFORMATION Patient First Name Mid. Initial Last Name Address City, State Zipcode Relationship to primary policyholder: ___Self ___Spouse ___Dependent Child ___Other: ___ 2. POLICYHOLDER / SUBSCRIBER INFORMATION FOR PRIMARY INSURANCE First Name Mid. Initial Last Name Address City, State Zipcode Contact Number _____Social Security # Employer Plan / Group # Insurance Company Name Member ID

Do you have SECONDARY or other orthodontic coverage? _____

If YES continue to section 3, if NO please continue to section 4 and 5.

3. POLICYHOLDER / SUBSCRIBER INFORMATION FOR SECONDARY INSURANCE

First Name	Mid. Initial	Last Name		
Address		City, State	Zipcode	
1 1				
Date of Birth	Social Security #	Contact Num	nber	
Employer		Plan / Group #		
Insurance Company Name		Memb	per ID #	
Address		City, State	Zipcode	
Patient's relationship to SE	CONDARY policy holder: _	SelfSpouse Other:		
4. I have been informed o charges for orthodontic s prohibited by law, or the prohibiting all or a portion disclosure of my protected claim.	ervices and materials no treating dentist or dental n of such charges. To the	t paid for by my do practice has a cor e extent permitted	ental benefit plan, unle ntractual agreement wi by law, I consent to yo	ess th my plan our use and
Patient / Guardian Signatur	e Date			
5. I hereby authorize and Ellender Orthodontics.	direct payment of the de	ntal benefits other	wise payable to me, di	rectly to
	e Date			