smile.
A BOUTIQUE
INVISALIGN EXPERIENCE

PATIENT INFORMATION

PATIENT NAME: ◯ M ◯ F BIRTHDATE:

PATIENT NAME: ◯ M ◯ F BIRTHDATE:

RELATIONSHIP TO POLICY HOLDER (Please circle one): SELF SPOUSE CHILD OTHER

DENTAL INSURANCE INFORMATION

PLEASE PROVIDE COPY OF DENTAL INSURANCE CARD

INSURANCE COMPANY:

MAILING ADDRESS: CITY: STATE: ZIP:

INSURANCE COMPANY PHONE #: POLICY #: GROUP#:

POLICY HOLDER NAME:

ADDRESS (if different from patient): CITY: STATE: ZIP:

BIRTHDATE: SS#:

EMPLOYER:

EMPLOYER ADDRESS: CITY: STATE: ZIP:

RELATIONSHIP TO PATIENT (Please circle one): SELF SPOUSE CHILD OTHER

IS PATIENT COVERED BY ANOTHER ORTHODONTIC INSURANCE PLAN: YES NO

If yes, ask for additional form please

BOTH LINES NEED TO BE SIGNED

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

I AUTHORIZE PAYMENT OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO ORTHODONTIC ASSOCIATES.

PATIENT OR PARENT IF MINOR DATE

POLICY HOLDER (signature) DATE

POLICY HOLDER (printed name)

FOR OFFICE USE ONLY

% OF COVERAGE _____ WAITING PERIOD YES NO

MAX $ _____ AGE RESTRICTION YES NO

USED IF ANY $ _____ PAYS FOR RECORDS YES NO

HOW PAID OUT _____ STAFF WHO CALLED:_____ DATE_____