ALLEGHENY ORTHODONTIC ASSOCIATES
ORTHODONTIC INSURANCE INFORMATION

If the patient is covered under a dental plan with an orthodontic benefit, please complete the following information and bring this information with you to the examination. In order to assist you in determining your orthodontic insurance benefit, the following information is necessary:

Patient Name _____ Date of Birth _____

Name of Insured _____ Date of Birth _____

Address _____

Social Security # _____ Phone _____

Employer _____ Phone _____

Dental Insurance Company _____

Insurance Company Address/Phone _____

_____

Policy # _____ Group # _____

If patient has a secondary dental insurance under another plan, please complete the following information:

Name of Insured _____ Date of Birth _____

Address _____

Social Security # _____ Phone _____

Employer _____ Phone _____

Dental Insurance Company _____

Insurance Company Address/Phone _____

_____

Policy # _____ Group # _____

I hereby authorize release of insurance information to Allegheny Orthodontic Associates.

_____ Date _____

(signature)

***** PLEASE TELL US HOW YOUR HEARD ABOUT OUR OFFICE *****

Your Dentist _____ Dentist's Name _____

Friend/Family _____ Name of this person _____

Our Employee _____ Name _____

Website _____ Mailer _____ Insurance Company _____ Other _____