FINANCIAL RESPONSIBLE & DENTAL INSURANCE INFORMATION

(WE DO NOT NEED YOUR HEALTH INSURANCE INFORMATION)

Insured's Name ___________________________________ Policy Holder Date of Birth ______________________
(Name of Policy Holder)
Insurance Co. ______________________________Insurance Co. Address ________________________________

Insurance Co. Phone Number ______________________Insured's Employer ____________________________

Employer Address _______________________________Insured's Social Security # ________________________

Group No. __________________ Identification No.____

IF YOU HAVE DUAL DENTAL INSURANCE COVERAGE :

Insured's policy holder Name ______________________________________ Policy Holder Date of Birth _____________
Insurance Co. _________________________________Insurance Co. Address _________________________________
Insurance Co. Phone Number _________________________Insured's Employer ____________________________

Employer Address ___________________________________Insured's Social Security # ______________________

Group No. _________________________ Identification No.____

Flex Spending __________YES ___________NO

Financial responsible for account_______________________________DOB___________SS#____________________

Email________________________________Cell__________________________Address________________________

Father or Other Parent Name_____________________________Cell____

Email____Address____

If Divorce is involved, who is the custodial parent?________________________________

May patient information be released to non custodial parent?______________________

I will do everything necessary to assist the office of Christie, Drane & Forwood Family Orthodontics in receiving the credited insurance benefits, if any, by completing and submitting any necessary forms, as well as communicating all and any change in my insurance benefit. I am aware that I, not my insurance company, am responsible for all balances on the account, whether or not the insurance company pays the full expected benefit allowance. In addition, this will serve as a signature on file for the submission of all insurance claims and assignment of benefit to the above named office.

___________________________________	_____________	___________________________________	_____________
Release of Information Signature of Patient or Parent if Minor	Date	Authorize Payment directly To Dentist	Date

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Signature:____ Date:___________________