

Insurance Questionnaire

We are happy to assist in the processing of your insurance, however, in doing so, we are not accepting the responsibility for your coverage. You are ultimately responsible for the treatment fee and the entire insurance process and coverage. We will also need a copy of your insurance card for our records.

Please complete the following insurance questions:

Do you have orthodontic coverage? If YES, then proceed.

Patient name _____

Name of Insured _____

Name of Employer _____

Name of Insurance Company _____

Address of Insurance Co. _____

Phone # of Insurance Co. _____

Group # _____

Effective Date of Coverage _____

I.D. # _____

For orthodontic treatment only:

Maximum benefit amount _____

Benefit amount remaining _____

Rate of Pay (%) _____

Where applicable, does it cover adults? _____

When dual insurance, does secondary insurance coordinate benefits? _____

Where applicable, does it cover treatment in progress? _____

I understand that if my insurance does not pay, I am responsible for the balance.

Signature