Orthodontic Insurance Information Sheet
(Under Dental Insurance, Not Medical Insurance)

Patient Name ______________________________ Date of Birth ______________

Full Time Student? Yes or No

Primary Insurance

Subscriber Name ______________________________

Subscriber Address ______________________________
(if other than patient)

Subscriber Date of Birth ______________ Relationship to Patient ______________

Insurance ID # or Subscriber SS # ______________ Group # ______________

Employer (company) Name ______________________________

Address ______________________________

Insurance Company Name ______________________________

Address ______________________________

Phone # ______________

Secondary Insurance

Subscriber Name ______________________________

Subscriber Address ______________________________
(if other than patient)

Subscriber Date of Birth ______________ Relationship to Patient ______________

Insurance ID # or Subscriber SS # ______________ Group # ______________

Employer (company) Name ______________________________

Address ______________________________

Insurance Company Name ______________________________

Address ______________________________

Phone # ______________

I hereby authorize payment directly to Dr. Barry E. Booth of the group insurance benefits otherwise payable to me.

► ______________________________ Date ______________

Signed (Primary Insured Subscriber)