Martin Orthodontics
Insurance Information

The following information regarding your insurance coverage is necessary to process your insurance claim. Please complete the following to expedite your claim and to insure that you receive the maximum benefit available.

Please remember your insurance is a contract between you and your insurance provider. You are responsible for understanding your benefits deductibles, limitation and exclusions.

Patient's Name:_____ DOB:_____

Name of Subscriber: _____DOB:_____

Address:_____Zip:_____

Telephone Number: _____SS#: _____

Insurance Company:_____

Address: _____

Telephone Number: _____Member/Subscriber Id: _____

Plan or Group Number: _____

How long have you had this policy: _____

Does your policy have orthodontic coverage: _____

Name of Employer/Company: _____

Address: _____

Telephone Number: _____

By signing below I authorize release of any information pertaining to treatment and authorize payment of dental benefits directly to Martin Orthodontics**. I also acknowledging that I am responsible for understanding my dental insurance's, policies, benefits, deductibles, limitations and exclusions. I acknowledge any estimate provided by Martin Orthodontics is an estimate and not a final bill.**

Signature: _____Date: _____

Print Name: _____ Relationship to Patient: _____

Office use ONLY: