



DENTAL INSURANCE INFORMATION



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Tampa, FL 33629
(813) 254-8005

If you have orthodontic insurance and would like us to file a pre-determination of benefits, **please fill out this form and the top portion of your insurance claim forms.** Please bring both forms to your next visit with us. If you are planning for us to received benefits from your insurance company, please be sure to sign and date the line authorizing the insurance company to pay benefits to the dentist.

DENTAL INSURANCE COMPANY

Insurance Company Name: _____
Insurance Company Address: _____
City: _____ State: _____ Zip: _____
Insurance Company Phone #: _____
Insurance Policy #: _____ Insurance Group #: _____
Is this insurance carrier? Primary: _____ Secondary: _____ (Please check one)

PRIMARY INSURED INFORMATION

Insured Name: _____
Insured Address: _____
City: _____ State: _____ Zip: _____
Insured Phone #: _____
Insured Social Security #: _____ Birthdate: ____ / ____ / ____
Insured Employer: _____
Employer Address: _____
City: _____ State: _____ Zip: _____
Employer Phone #: _____

PATIENT INFORMATION

Patient Name: _____
Patient Address (if different from insured): _____
City: _____ State: _____ Zip: _____
Patient Social Security # _____ Birthdate: ____ / ____ / ____

Please remember to bring this completed form along with one of your completed insurance claims forms to your first visit. **Thank you!**

OFFICE USE ONLY

Ortho Benefit: \$ _____ Lifetime or Yearly Remaining Benefits: \$ _____
Age Limit: YES or NO If yes, what age? _____ Adult Coverage? _____
Initial Payment: _____ % Monthly or Quarterly _____ % As Billed or Automatic
Deductible: \$ _____ Lifetime or Yearly Any waiting periods? YES or NO
Payments to: PROVIDER or SUBSCRIBER Records: _____ %
Pre-Determination Required: YES or NO
Effective Date: _____
Verification Date: _____
Verified By: _____