DENTAL INSURANCE INFORMATION

Today's Date | Please complete if you *have* Orthodontic Coverage

Patient Name | Patient DOB

	PRIMARY Policy	SECONDA
Insurance Company		
Group #		
Covered Employee Name		
Employee DOB		
Covered Employee SS#		
Covered Employee Address		
Employer		
Employee ID#(if different from SS#)		

OFFICE USE ONLY

	PRIMARY	SECONDA
Ins. Co		Ins. Co
Claims Address		Claims Address
Phone #		Phone#
Lifetime Max	To Age:	Lifetime Max To Age:
Pay %	Used:	Pay% Used:
Effective Date		Effective Date
Date Appliances Placed		Date Appliances Placed
Mo Adj Amount		Mo Adj Amt
Filing : Auto	Mthly Qtrly	Filing: Auto Mnthl
Requires COT's yes	no	Requires COT's yes

Treatment : Phase I Phase II Comp. Retainer Records

Total Fee

Down Payment

ARY Policy

ARY

y Qtrly

no

Other