

North Seattle Orthodontics

11011 Meridian Ave N, Suite 304 Seattle, WA 98133 (206) 523-1047

ORTHODONTIC INSURANCE INFORMATION

In order to assist you in determining your orthodontic benefits, the following information is necessary:

| | |
|--------------------------------------|-----------------------------|
| Name of Patient: _____ | Date of Birth: _____ |
| Name of Insured: _____ | Date of Birth: _____ |
| Address of Insured: _____ | |
| Soc Security # or ID #: _____ | Telephone #: _____ |
| Employer Name: _____ | Telephone #: _____ |
| Insurance Company: _____ | Group #: _____ |
| Insurance Company Address: _____ | |
| Insurance Company Telephone #: _____ | Primary or Secondary? _____ |

Effective Date *~for office use only~*

| | | |
|--|----------------------------------|------------------------------|
| date chkd: _____ | chkd by: _____ | contact person: _____ |
| LTM: \$ _____ year / lifetime | paid at: _____ % | deductible: \$ _____ |
| age limit: _____ | need to pre-authorize? _____ | |
| amount used to date? \$ _____ | does plan pay banding fee? _____ | |
| how is benefit paid? monthly/ quarterly/ 2 pay plan/ annual/ other | we bill ~or~ auto | |
| if coverage is secondary, how is benefit paid? _____ | | |
| comments: _____ | | |
| What is the coordination with other benefits? _____ | | |
| Waiting Period: _____ | If yes, how long? _____ | electronic payer ID #: _____ |

Is patient covered under another dental plan? If so, please complete the following information:

| | |
|--------------------------------------|-----------------------------|
| Name of Insured: _____ | Date of Birth: _____ |
| Address of Insured: _____ | |
| Soc Security # or ID #: _____ | Telephone #: _____ |
| Employer Name: _____ | Telephone #: _____ |
| Insurance Company: _____ | Group #: _____ |
| Insurance Company Address: _____ | |
| Insurance Company Telephone #: _____ | Primary or Secondary? _____ |

effective date: *~for office use only~*

| | | |
|--|----------------------------------|------------------------------|
| date chkd: _____ | chkd by: _____ | contact person: _____ |
| LTM: \$ _____ year / lifetime | paid at: _____ % | deductible: \$ _____ |
| age limit: _____ | need to pre-authorize? _____ | |
| amount used to date? \$ _____ | does plan pay banding fee? _____ | |
| how is benefit paid? monthly/ quarterly/ 2 pay plan/ annual/ other | we bill ~or~ auto | |
| if coverage is secondary, how is benefit paid? _____ | | |
| comments: _____ | | |
| waiting period? _____ | If yes, how long? _____ | electronic payer ID #: _____ |

I hereby authorize release of any information relating to this claim.

Signature Date: _____

I hereby authorize payment of insurance benefits directly to the above named orthodontists.

Signature Date: _____

Please notify our office of any changes in your insurance policy as soon as possible, thank you.