BALLRICK ORTHODONTICS, Inc.

DENTAL INSURANCE INFORMATION

Patient to fill out top portion:

Please fill out following insurance information for dental coverage. Should treatment be indicated, we will submit all the necessary information.

PATIENT NAME: ___________________________________ DATE OF BIRTH:________________________

Primary Dental Insurance:

Subscriber Name:_____________________________ Subscriber Date of Birth:_______________________

Policy I.D. #__________________________________ Subscriber SS#_______________________________

Group/Plan#_________________________________ Employer___________________________________

Dental Insurance Carrier____

Dental Insurance Address____

____

Dental Insurance Phone # ____

Office Staff to fill out:

Deductible________________________________ Amount Met___________________________________

Lifetime Max______________________________ Age Limit ______________________________________

% Paid ___________________________________ Quarterly/ Monthly _____________________________

Rep Name_________________________________ Date____

Notes: