ORTHODONTIC INSURANCE INFORMATION

In order to verify your orthodontic benefits, the following information is needed:

Name of Patient ________________________________ Patient Date of Birth:_________________

Name of Insured (Subscriber):_____________________ Insured Date of Birth:_________________

Member/Subsciber ID #:___________________________ Group #: _________________________
(Or Social Security Number)

Employer Name ___________________________________

Insurance Company:______________________________ Phone Number:____________________

Insurance Company Address: ____

More than one insurance plan? Please enter the additional coverage information here.

Name of Insured (Subscriber):_____________________ Insured Date of Birth:_________________

Member/Subsciber ID #:___________________________ Group #: _________________________
(Or Social Security Number)

Employer Name ___________________________________

Insurance Company:______________________________ Phone Number: ____________________

Insurance Company Address:____

I hereby authorize payment of insurance benefits directly to Dr. Elizabeth Lyons.

Signature of Subscriber:__________________________________ Date:__________________

Please notify our office of any changes in your insurance policy as soon as possible!