

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 #: _____ <small>(Or Social Security Number)</small>	Group #: _____
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 #: _____ <small>(Or Social Security Number)</small>	Group #: _____
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!

