INSURANCE INFORMATION FORM

This form must be completed in order for our office to verify your insurance and provide a realistic estimation of what the patient's financial responsibility will be.

patient first name	middle name	last name	date of birth

PRIMARY INSURANCE POLICY

name of insurance company			insurance telephone #
contract or id #		group #	
policy holder first name	middle name	last name	date of birth
policy holder employer		policy holder social security #	

SECONDARY INSURANCE POLICY

name of insurance company			insurance telephone #
contract or id #		group #	
policy holder first name	middle name	last name	date of birth
policy holder employer		policy holder social security #	

MEDICAL INSURANCE POLICY (If a TMJ patient only)

name of insurance company			insurance telephone #
contract or id #		group #	
policy holder first name	middle name	last name	date of birth
policy holder employer		policy holder social security #	

INSURANCE NOTES

This form is used for the purpose of verifying patient insurance and facilitating the process of filing once treatment has been completed.

As a courtesy, if your insurance policy includes orthodontic benefits, we will file a claim for payment from your insurance company. We will also file your records (pictures, x-rays, etc.) under the dental portion of your policy.

Pickett ORTHODONTICS LLC