Orthodontic Insurance Information

If you have an insurance plan or union contract that pays a part of your orthodontic fee, we will be happy to assist you in claiming your benefits. With increasing numbers of dental insurance programs, we find it impossible to have a complete and accurate knowledge about all of these programs and our individual patient's status with respect to his own program. In order to process your insurance claim properly we need the following information.

Patient Information

Name________________________________Address____

City________________________State________Zip Code__________Home phone__________________

Relationship to the insured: Self Child Spouse Other____________Date of Birth_____________

Insured Person Information

Name______________________________Address____

City________________________State______Zip Code________Social Security#__________________

Date of Birth_____________Status: Married Single Other________

The insured works for__________________________________Work Phone #______________________

Insurance Information

You must contact your insurance company to obtain the information below. Be sure to speak with the Orthodontic department.

Name of insurance co.__________________________ Phone #__________________________________

Address of insurance co.________________________________City________________State_________

Zip Code________Group #_______________Lifetime maximum _____________% paid at___________

Date insurance went into effect________________________ Monthly or Quarterly

Insurance policies and payment programs can be confusing, we require that patients contact their insurance company to confirm that their assumptions regarding coverage for orthodontic treatment are correct. Please request this information in writing from your insurance company. Patients must realize that professional services are rendered to a person, not an insurance company. The insurance company is responsible to the patient and the patient is responsible to us. We cannot render services on the assumption that the charges will be paid by an insurance company. However, we will help in any way we can.

Please sign below:

1. I authorize the release of any information relating to this claim. I understand that I am responsible for all cost of orthodontic treatment.

Signature______________________________________**Date**____________________________________

2. I hereby authorize insurance payment DIRECTLY to J. Jeff Kincaid, D.M.D., M.S.

Signature______________________________________**Date**____________________________________