ALBANY BRACES

INSURANCE INFORMATION SHEET

Please provide us with any medical or dental cards you may have so we can make a copy.

PATIENT INFORMATION **PLEASE PRINT (*BLACK/BLUE INK*) **

PATIENT'S FULL NAME:_____DOB:_____

PRIMARY DENTAL INSURANCE INFORMATION

NAME OF POLICY HOLDER:_____ EMPLOYED BY:_____
LENGTH OF EMPLOYMENT:_____

DENTAL INSURANCE CO:_____ POLICY HOLDER SSN#:_____

INSURANCE CO. ADDRESS: _____
_____ SUBSCRIBER ID:_____ POLICY HOLDER DOB:_____

INSURANCE CO. PHONE:_____ RELATION TO PATIENT:_____

SECONDARY DENTAL INSURANCE INFORMATION

NAME OF POLICY HOLDER:_____ EMPLOYED BY:_____
LENGTH OF EMPLOYMENT:_____

DENTAL INSURANCE CO:_____ POLICY HOLDER SSN#:_____

INSURANCE CO. ADDRESS: _____
_____ SUBSCRIBER ID:_____ POLICY HOLDER DOB:_____

INSURANCE CO. PHONE:_____ RELATION TO PATIENT:_____

DOES THE PATIENT HAVE A PEDIATRIC DENTAL BENEFIT ON A MEDICAL PLAN? ____YES____NO

IF CHECKED "YES", MEDICAL INFORMATION BELOW IS REQUIRED. IF YOU ARE UNSURE, PLEASE CONTACT YOUR MEDICAL INSURANCE CARRIER AND NOTIFY US.

PRIMARY MEDICAL INSURANCE INFORMATION

NAME OF POLICY HOLDER:_____ EMPLOYED BY:_____
LENGTH OF EMPLOYMENT:_____

MEDICAL INSURANCE CO:_____ POLICY HOLDER SSN#:_____

INSURANCE CO. ADDRESS: _____
_____ SUBSCRIBER ID:_____ POLICY HOLDER DOB:_____

INSURANCE CO. PHONE:_____ RELATION TO PATIENT:_____

SECONDARY MEDICAL INSURANCE INFORMATION

NAME OF POLICY HOLDER:_____ EMPLOYED BY:_____
LENGTH OF EMPLOYMENT:_____

MEDICAL INSURANCE CO:_____ POLICY HOLDER SSN#:_____

INSURANCE CO. ADDRESS: _____
_____ SUBSCRIBER ID:_____ POLICY HOLDER DOB:_____

INSURANCE CO. PHONE:_____ RELATION TO PATIENT:_____

NOTE: COMPLETE INSURANCE INFORMATION IS IMPERATIVE TO ENSURE ACCURATE PROCESSING OF YOUR INSURANCE CLAIM.