



Insurance Information

87 Newtown Lane, East Hampton, NY 11937

We welcome your insurance information to be able to assist in getting your full benefit from your insurance carrier. Please understand that should the claim be denied, you are still responsible for the cost of treatment.

| | | | | | |
|----------------|--|---------------|--|------|--|
| Patient's Name | | Date of Birth | | SS # | |
|----------------|--|---------------|--|------|--|

| | | | | | |
|--|--|---------------|---------|------------------------------|-----------------------------|
| Primary Insurance (Person whose birthday is first, not including the year) | | | | | |
| Subscriber's Name | | Date of Birth | | SS # | |
| Relationship to patient | | Employer | | | |
| Employer Address | | | Phone # | | |
| Name of Insurance Company | | | Phone # | | |
| Policy # | | Group # | | Plan Name | |
| Have you checked with your insurance company for orthodontic coverage? | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If so, what benefit do you have? | | | | | |

| | | | | | |
|---|--|---------------|---------|------------------------------|-----------------------------|
| Secondary Insurance (Person whose birthday is second, not including the year) | | | | | |
| Subscriber's Name | | Date of Birth | | SS # | |
| Relationship to patient | | Employer | | | |
| Employer Address | | | Phone # | | |
| Name of Insurance Company | | | Phone # | | |
| Policy # | | Group # | | Plan Name | |
| Have you checked with your insurance company for orthodontic coverage? | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If so, what benefit do you have? | | | | | |