770-448-8882

CHANGE OF INSURANCE FORM

Date ________________

This is NOT a guarantee of benefits or payment. Actual benefits can not be determined until actual claim is received by carrier. As per contract patient is responsible for any balance denied or rejected by insurance carrier

Patient Name __________________________ Account Number _____________________________

Date of Birth _______________ Location _________________ Initial Start Date ___________________

Policy Holder's Name ___________________________________ Policy Holder DOB_______________

Policy Holder's Address ____Zip Code_______________

Employer _______________________________________ Insurance Company ____________________

Insurance Co. Phone Number _________________ Group Number _____________________________

Policy Holder Social Security Number ____

****Copy of Insurance card attached****

INFORMATION AND PAYMENT AUTHORIZATION RELEASE

I authorize the release of any information relating to this claim and understand that I am responsible for all costs of dental treatment.

_____________________________/_____________
Signature (responsible party) Date

I hereby authorize payment directly to **Family Orthodontics** of the group insurance benefits otherwise payable to me.

_____________________________/_____________
Signature (responsible party) Date