willow lake
ORTHODONTICS

Dental Insurance Form

DATE: _____

PATIENT'S NAME: _____ DOB: _____

EMPLOYEE'S INFORMATION

Insured Name: _____ Relationship To Patient: _____

Insured DOB: _____ Insured SSN: _____

Insured ID#: _____ Group #: _____

EMPLOYER'S INFORMATION

Employer's Name: _____

Employer's Address: _____

Employer's Phone Number: _____

DENTAL INSURANCE INFORMATION

Insurance Provider: _____

Insurance Address for Billing Claims: _____

_____

Insurance Phone #: _____ Insurance Fax #: _____

OFFICE USE ONLY

Effective Date: _____ Lifetime Max: $_____ % _____

Deductible: Yearly $_____ Lifetime $ _____

Amount Used $_____ Paid $ _____

Dispursement Schedule: Monthly _____ Quarterly _____ Annual _____