KAY & McCULLUM ORTHODONTICS

25 Boulder Hill Pass, Montgomery, IL 60538
Telephone (630) 896-2779
Fax (630) 896-9252

Verified Date: _____
Ortho Max_____%_____
Used_____Age_____
Adults_____Add Verf.____
Terms_____
_____
TX Dates_____
TX_____
Fees_____

Date: _____

Notes:

Please PRINT Legibly

PATIENT INFORMATION

Name: _____Nickname: _____
First Middle Last

Birthdate: _____

Primary Dental Insurance

Effective Date: _____

Is this an Affordable Care Plan? Yes ☐ No ☐

Insured Person: _____Insurance ID#_____

Relationship to Patient: _____Birthdate: _____Social Security Number: _____

Employer's Name: _____Group Number: _____

Insurance Company Name: _____Phone Number: ( ) _____

Insurance Company Address: _____

City: _____State: _____Zip: _____

Failure to fill all the information may cause a delay in submitting your claim to the insurance company.

Ortho max: _____
Used: _____ %_____
Age: _____ Adults: ____

Secondary Dental Insurance

Effective Date: _____

Is this an Affordable Care Plan? Yes ☐ No ☐

Insured Person: _____Insurance ID#_____

Relationship to Patient: _____Birthdate: _____Social Security Number: _____

Employer's Name: _____Group Number: _____

Insurance Company Name: _____Phone Number: ( ) _____

Insurance Company Address: _____

City: _____State: _____Zip: _____

Assignment and Release of Benefits

I, the undersigned, certify that I (or my dependent) do have insurance coverage with _____ and **assign directly to Kay & McCullum Orthodontics all insurance benefits**, if any, otherwise payable to me for services rendered. I understand that I am financially liable for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the release of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature Relationship Date