Notes

KAY ORTHODONTICS

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Fax to: 630-896-9252

Verified Date _____
Ortho Max_____%_____
Used_____Age_____
Adults_____Add Verf._____
Terms_____
_____
_____
TX Dates_____
TX OP1_____
EST_____
TX OP2_____
EST_____

Date: _____

PATIENT INFORMATION

Name:_____Birthdate:_____
First Last

PRIMARY DENTAL INSURANCE

Effective Date: _____

Is this coverage under Medical 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 _____Add Verf____
Terms_____
_____
TX OP1 EST_____
TX OP2 EST_____

Effective Date: _____

SECONDARY DENTAL INSURANCE

Is this coverage under a Medical 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 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