PATIENT INFORMATION

Last Name	First Name	Nickname	SS NO.	Sex	Birthdate	Age

Mailing Address	City	State	Zip	Home Phone

School (ifstudent)	Grade	{ }Single { }Married { }Sep { } Divorced { } Widow(er)	Employed By/Occupation	Business Phone

Email	Fax	Cell Phone

Who may we Thank for recommending us?	Name of Dentist	Date of last visit

Related patients that are or have been under our care	Names and Ages of other children

PARENT/ BILLING PARTY INFORMATION(please complete if patient is a minor)

PRIMARY NAME_____

ADDRESS(If different from patient)_____

_____

CITY_____ST_____ZIP_____

HOME PHONE_____WORK PHONE_____

CELL PHONE_____DOB_____

SS no._____EMAIL_____

EMPLOYER_____

ADDRESS_____

CITY_____ST_____ZIP_____

INSURANCE CO:_____

GROUP #_____POLICY ID:_____

INSURANCE CLAIMS ADDRESS:

_____

_____

INSURANCE TELEPHONE #:_____

SECONDARY NAME_____

ADDRESS(If different from patient)_____

_____

CITY_____ST_____ZIP_____

HOME PHONE_____WORK PHONE_____

CELL PHONE_____DOB_____

SS no._____EMAIL_____

EMPLOYER_____

ADDRESS_____

CITY_____ST_____ZIP_____

INSURANCE CO._____

GROUP #_____POLICY ID:_____

INSURANCE CLAIMS ADDRESS:

_____

_____

INSURANCE TELEPHONE #:_____

PLEASE NOTIFY OUR OFFICE OF ANY CHANGES IN YOUR INSURANCE CARRIER AS SOON AS POSSIBLE.

INSURANCE PAYMENTS

The majority of insurance policies pay only a percent of the orthodontic fee based on your employer's contract with them. Ultimately, what your insurance carrier pays is between you, the carrier and the contract between your employer and the insurance carrier.

Upon presentation of your insurance card, we attempt to obtain a verbal description of coverage prior to claim submission. Verbal confirmation however does not guarantee payment. Benefit determination can be made only when a claim is submitted payable subject to your plan provisions and the coordination of benefits with other group plans when applicable.

AUTHORIZATION STATEMENT

I authorize the release of information necessary to process any claim for services provided by Foster Orthodontics, and payment of benefits directly to Foster Orthodontics. A copy of this authorization may be used in place of the original. I understand that I am responsible for any balances not covered by insurance.

Patients/Parents or members are responsible for notifying Foster Orthodontics of any changes in orthodontic coverage, policy status, or change of carrier/administrator.

Name of Policyholder:_____

Signature:_____