Curtis Orthodontics
Braces for All Ages

Insurance Information

Primary Insurance

Subscriber Name_____

Relationship to Patient_____

Birthdate _____ / _____ / _____

SS# _____-_____-_____

Insurance Company _____

Group#_____

Secondary Insurance

Subscriber Name_____

Relationship to Patient_____

Birthdate _____ / _____ / _____

SS# _____-_____-_____

Insurance Company _____

Group#_____

Other Insurance

Subscriber Name_____

Relationship to Patient_____

Birthdate _____ / _____ / _____

SS# _____-_____-_____

Insurance Company _____

Group#_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Curtis all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ / _____ / _____

Responsible party signature **Date**

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

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Member American Association of Orthodontists