AMHERST ORTHODONTICS
FINANCIAL FORM

Patient's Name: _____ **D.O.B.:** _____

DENTAL INSURANCE INFORMATION			
Subscriber Name:	**Date of Birth:**	**Relationship to Patient:**	
Employer:		**# of years with Current Employer:**	
Social Security #:	**Alternate ID#:**	**Group #:**	
Insurance Carrier:		**Phone:**	
Address:	**City:**	**State:**	**Zip:**
ORTHODONTIC BENEFITS			
Lifetime Orthodontic Benefit:	**Paid at %:**	**Effective Date:**	
Ortho Benefit Used:	**Ortho Deductible:**	**Age Limit:**	
Waiting Period:		**Payment Schedule:**	
DENTAL BENEFITS			
Annual Dental Max:	**Individual Deductible:**	**Family Deductible:**	
Dental Benefit Used:			
DO YOU HAVE DUAL COVERAGE? YES ☐ NO ☐	**IF YES, PLEASE COMPLETE SECONDARY INFORMATION BELOW**		
Subscriber Name:	**Date of Birth:**	**Relationship to Patient:**	
Employer:		**# of years with Current Employer:**	
Social Security #:	**Alternate ID#:**	**Group #:**	
Insurance Carrier:		**Phone:**	
Address:	**City:**	**State:**	**Zip:**
Lifetime Orthodontic Benefit:	**Paid at %**	**Effective Date:**	
Ortho Benefit Used:	**Ortho Deductible:**	**Age Limit:**	
Dental Annual Max:	**Deductible:**	**Dental Benefit Used:**	

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical/dental status or personal information.

_____ _____

SIGNATURE *DATE*

All questions contained in this questionnaire are strictly confidential and will become part of the dental record.