## **Amherst Orthodontics Insurance Form**

Please note that this is confidential and submitting this information is secured. SSN is only requested and used so that we may help you verify your orthodontic benefits.

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DENTAI	L INSURNACE INFORMATION
(Please refer to y	our card and complete for each policy available)
Subscriber Name:	Subscriber Date of Birth:
Relationship to Patient:	Subscriber Social Security (if no ID number on card):
Insurance Company:	Group Number:
Subscriber ID Number:	Insurance Phone Number
Townson - Mailing Address	
Insurance Mailing Address:	
Insurance Mailing Address:	
Insurance Mailing Address:	
SECONDARY I	DENTAL INSURNACE INFORMATION
SECONDARY I (Please refer to y	our card and complete for each policy available)
SECONDARY I (Please refer to y	
SECONDARY I  (Please refer to y  Subscriber Name:	our card and complete for each policy available)  Subscriber Date of Birth:
	our card and complete for each policy available)
SECONDARY I (Please refer to y Subscriber Name: Relationship to Patient:	our card and complete for each policy available)  Subscriber Date of Birth:
SECONDARY I  (Please refer to y  Subscriber Name:	our card and complete for each policy available)  Subscriber Date of Birth:  Subscriber Social Security (if no ID number on card):
SECONDARY I (Please refer to y Subscriber Name: Relationship to Patient:	our card and complete for each policy available)  Subscriber Date of Birth:  Subscriber Social Security (if no ID number on card):