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.

PATIENT INFORMATION	
Patient Name:	Date of Birth:

DENTAL INSURNACE INFORMATION (Please refer to your 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
Insurance Mailing Address:	

SECONDARY DENTAL INSURNACE INFORMATION (Please refer to your 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
Insurance Mailing Address:	