KING ORTHODONTICS
FOR THE SMILE OF YOUR LIFE

This form is to be used so that our office is allowed to submit a generic insurance form on your behalf. Please read the statements below and place your signature on the provided line.
Thank You.

Effective Date: _____

Patient Name: _____
Patient Date of Birth: _____
Policy Holder's Name: _____
Policy Holder's Address: _____
_____
Policy Holder's Home Phone #: _____
Policy Holder's Work/Cell Phone #: _____
Policy Holder's Date of Birth: _____
Policy Holder's SS#: _____
Insurance ID# (If applies, other than SS#): _____
Policy Holder's Employer: _____
Insurance Co. Name: _____
Policy/Group #: _____
Insurance Co. Address: _____
_____
Insurance Co. Phone #: _____

Is patient covered by another plan or Orthodontic Benefits? Yes No
I have reviewed the treatment plan. I authorize the release of any information relating to this claim.

_____
Policy Holder Signature Date

I hereby authorize payment directly to the provider of treatment.

_____
Policy Holder Signature Date

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