

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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400 E. Yellow-Springs Road
Fairborn, OH 45324
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