

ORTHODONTIC CONSULTANTS OF SAINT LOUIS

Please bring this completed form to your consultation visit.

INSURANCE INFORMATION

Please fill out the following information and **ALSO** provide us with a completed dental claim form and/or a photocopy of the front and back of your **DENTAL/ORTHODONTIC** insurance card.

Please do **not** list medical insurance information.

Today's Date:	
Patient Name:	Patient's Date of Birth:
Name of Dental/Orthodontic Insurance Plan:	
Name of Policy Holder:	
Policy Holder's Employer:	
Policy Holder's Social Security # or Assigned ID #:	
Policy Holder's Date of Birth:	
Group #:	
Mail Claims To:	
Insurance Customer Service Phone #:	

For Office Use Only

Effective Date of Policy:
Lifetime Maximum Benefits:
Coverage to Age:
Amount of Yearly Deductible: