ORTHODONTIC CONSULTANTS OF SAINT LOUIS

DENTAL INSURANCE INFORMATION

(PLEASE DO NOT LIST MEDICAL INSURANCE INFORMATION)

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

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 # _____

OFFICE USE ONLY:

Effective Date of Policy: _____
Lifetime Maximum Benefits: _____ **Co-Insurance:** _____
Orthodontic Age Limit: _____
If applicable - Adult Orthodontic Coverage: YES or NO

Deductible: YES or NO If yes: One-time or Yearly

Deductible Amount: _____

Required Filing: Monthly Claims or Auto Generated Payments

Coordination of Benefits: _____

Orthodontic Waiting Period: YES or NO If yes, Effective Date: _____

*Please Note: Many dental insurance companies still **ONLY** use social security numbers as identification for verifying coverage and filing claims. Please see the front desk with any questions or concerns.