willow lake
ORTHODONTICS

Dental Insurance Form

DATE: _____

PATIENT'S NAME:_____ DOB:_____

EMPLOYEE'S INFORMATION

Insured Name: _____ Relationship To Patient: _____

Insured DOB: _____ Insured SSN: _____

Insured ID#: _____ Group #: _____

Employer's Name: _____

DENTAL INSURANCE INFORMATION

Insurance Provider: _____

Insurance Address for Billing Claims: _____

_____

Insurance Phone #: _____ Insurance Fax #: _____

****Please note, Willow Lake Orthodontics is an out-of-network provider*

OFFICE USE ONLY

Effective Date: _____ Up to Age _____ Lifetime Max: $ _____ _____ %

Deductible: Yearly $ _____ Lifetime $_____

Amount Used $_____ Paid $_____

Disbursement Schedule: Monthly _____ Quarterly _____ Annual _____

Electronic Claim # _____ Preauthorization Needed: Yes / No

Waiting Period: Yes / No If Yes: _____ Cover Work in Progress: Yes / No