ORTHODONTICS
Tom Broderick, D.D.S., M,S,
Mark Dusek, D.D.S.,M.S.
Christopher DeLeon, D.M.D.

DATE _____
ACCOUNT# _____

***As a courtesy to you, we accept assignment of insurance benefits from most insurance companies. HOWEVER, the balance is your responsibility whether your insurance company pays or not. You must make sure we have your current insurance information on file. Your insurance policy is a contract between you and your insurance company. We are not party to that contract.**

PATIENT: First Name:_____ **Last Name:**_____ **Middle Initial:**_____
Preferred Name: _____ **DOB:** _____ **Age:**_____

DENTAL INSURANCE INFORMATION ONLY

PRIMARY ORTHODONTIC INSURANCE

Name of ***Insured (Policy Holder)***: **First Name:** _____ **Last Name:** _____ **Middle Initial:** __
Relationship to ***Patient***: Self___ Spouse___ Parent___ Step Parent ___
Insured's Address: _____ City, State, Zip: _____
Insured Soc. Sec. # _____ ***Insured*** Date of Birth: _____
Home Phone: _____ Cell Phone_____ Work Phone: _____

Employer: _____ Policy/Group#_____ Patient ID#_____
Insurance Company:_____ Effective Date of Coverage:_____
Insurance Co Address:_____ Phone_____
****I authorize release of any information relating to this claim.** _____
****I authorize payment directly to the dentist.** _____

SECONDARY ORTHODONTIC INSURANCE

Name of ***Insured (Policy Holder)***: **First Name:** _____**Last Name:** _____ **Middle Initial:** __
Relationship to ***Patien***t: Self___ Spouse___ Parent___ Step Parent ___
Insured's Address:_____ City, State, Zip:_____
Insured Soc. Sec.#_____ ***Insured*** Date of Birth:_____
Home Phone: _____ Cell Phone_____ Work Phone: _____

Employer:_____ Policy/Group#_____ Patient ID#_____
Insurance Company:_____ Effective Date of Coverage:_____
Insurance Co Address:_____ Phone_____
****I authorize release of any information relating to this claim.** _____
**** I authorize payment directly to the dentist.** _____