Aubrey Barrett Orthodontics
511 El Cerrito Plaza
El Cerrito, Ca 94530

ORTHODONTIC INSURANCE INFORMATION

Date: _____

In order to assist you in receiving the greatest benefit from your orthodontic insurance, it will be helpful to have the following information completed.

Patient Name _____ Date of Birth _____ Relationship to Insured _____

Insured Name _____ Date of Birth _____ Social Security # _____

Employer _____

Address _____

Insurance Co. _____ Policy or Group # _____

Insurance Co. Address _____

Insurance Co. Telephone (800 # if available) _____

If the patient is covered by a second insurance policy, please complete the following information for the second insu ance policy.

Insured Name _____ Date of Birth _____ Social Security # _____

Patient relationship to this insured _____

Employer _____

Address _____

Insurance Co. _____ Policy or Group # _____

Insurance Co. Address _____

Insurance Co. Telephone (800 # if available) _____

If the patient is covered by a third insurance policy, please complete the following information for the third insurance policy.

Insured Name _____ Date of Birth _____ Social Security # _____

Patient relationship to this insured _____

Employer _____

Address _____

Insurance Co. _____ Policy or Group # _____

Insurance Co. Address _____

Insurance Co. Telephone (800 # if available) _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

Signature (Patient or Parent of minor) _____ Date _____