Member American Associaton of **Orthodontists**

Drs.
Soderquist & Weis
orthodontics
Beautiful smiles for a lifetime

James P. Soderquist, D.D.S.
Barton D. Weis, D.D.S.
Diplomates, American Board of Orthodontics

PATIENT INSURANCE INFORMATION

***All information is necessary to avoid delays ***

PATIENT NAME_____

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

PATIENT BIRTHDATE_____

INSURED NAME_____

INSURED ADDRESS_____

_____

INSURED BIRTHDATE*_____

INSURANCE ID NUMBER*_____

INSURANCE GROUP NUMBER*_____

INSURANCE COMPANY NAME*_____

INSURANCE CO ADDRESS*_____

_____

EMPLOYER NAME*_____

IS THIS CLAIM THE RESULT OF AN ACCIDENT? YES NO

IS PATIENT COVERED BY ANOTHER DENTAL INSURANCE? YES NO

IF THERE IS A SECONDARY INSURANCE PLEASE REQUEST ANOTHER FORM TO FILL OUT AND INDICATE AT THE TOP THAT IT IS YOUR SECONDARY INSURANCE

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO ORTHODONTIC INSURANCE CLAIMS

_____

SIGNATURE DATE

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