STORMS ORTHODONTICS
Smiles by Storms

IF YOU HAVE ORTHODONTIC INSURANCE…

By completing the information below, we will be able to assist you in providing the most accurate payment option information possible.

-Please plan to bring this completed form and your current insurance card to your appointment -

PATIENT NAME: _____

Name of INSURANCE COMPANY: _____

INSURANCE Mailing Address: _____

_____

INSURANCE Phone Number: _____

POLICYHOLDER'S NAME: _____

Is policyholder's address different from patient: ☐ NO ☐ YES (If YES, list their mailing address on back of form)

Policyholder is the patient's: *DAD MOM STEP-PARENT SPOUSE OTHER*
(Circle One)

Policyholder's DATE OF BIRTH: _____ - _____ - _____
(Month) (Day) (Year)

ID and SSN: _____ / _____ - _____ - _____
(Insurance ID Number) *(Social Security Number)*

GROUP NUMBER: _____
*(If not listed on your card, enter your Employer Name- ex: Tyson Foods, Wal*Mart, etc.)*

Policyholder EMPLOYED BY: _____

IMPORTANT!

-Prior to your appointment, please obtain the following information-

Most insurance ID cards should list a toll-free number for you to verify your orthodontic benefits. Either follow the automated instructions or tell the customer service representative that you need to verify what type of benefits are available through your policy for **orthodontic** treatment, NOT *general dental benefits*. **There is a difference!**

TOTAL BENEFIT: $_____

Date you called your insurance company: _____
Name of the insurance rep you spoke with: _____
Is there an AGE LIMIT on this policy? ☐ Yes ☐ No *If so, limited up to age* _____
What type of orthodontic benefit is it? ☐ Lifetime Benefit ☐ Calendar Year Benefit
Benefits are payable at what percent? _____ **%** *(NOTE: This is almost always 50%)*

IMPORTANT: ***If this is a new policy, be sure to ask if there is a waiting period for orthodontics.***

On what date did the policy become effective? _____ Initials of caller: _____