OFFICE USE ONLY

MAX _____

PAID _____

AVAIL _____

ELIG _____

PAYOR ID _____

DATE _____

DENTAL INSURANCE INFORMATION

CAMBRIDGE ORTHODONTICS, P.A.

140 Birch St. N., #106 • Cambridge, MN 55008

(763) 689-3134 • Fax: (763) 689-6609

E-mail: cambridgeorthomn@msn.com

www.cambridgeorthomn.com

PATIENT NAME: _____ Date of Birth: _____

Name of Insured: _____ Relationship to Patient: _____

Social Security Number: _____ Date of Birth: _____

Employer: _____ ID#: _____

Dental Insurance Company: _____ Group Number: _____

Claims Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize the release of any information relating to dental claims for benefits submitted on behalf of myself, and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Cambridge Orthodontics to submit claims to my insurance carrier for dental benefits, for services rendered or to be rendered, without obtaining my signature on each individual claim to be submitted for myself and/or dependents.

Signed: _____ ***Date:*** _____

I hereby authorize payment of dental benefits, otherwise payable to me, directly to Cambridge Orthodontics.

Signed: _____ ***Date:*** _____

Please complete other side for 2nd insurance carrier.

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