SHENANDOAH VALLEY ORTHODONTICS

Damon DeArment, DDS
Daniel Lill, DDS, MS

ORTHODONTIC INSURANCE INFORMATION

In order to assist you in determining your orthodontic insurance benefit, the following information is necessary:

Name of Patient:		Date of Birth:	
Name of Insured:		Date of Birth:	
Address:			
Social Security #:		Telephone:	
Employed by:			
Insurance Company:		Policy #:	
Insurance Telephone:		Group #:	

Is patient covered under another dental plan? If so, please complete the following:

Name of Insured:		Date of Birth:	
Address:			
Social Security #:		Telephone:	
Employed by:			
Insurance Company:		Policy #:	
Insurance Telephone:		Group #:	

I hereby authorize release of any information relating to this claim.

Signature: _____ Date: _____

I hereby authorize payment of insurance benefits directly to the above named orthodontist.

Signature: _____ Date: _____

~PLEASE REMEMBER TO CALL US WITH ANY INSURANCE CHANGES DURING TREATMENT~

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1705 Amherst Street
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