SHENANDOAH VALLEY
ORTHODONTICS

Damon DeArment, DDS
Daniel Lill, DDS, MS
Ashley Larson DMD, MS

ORTHODONTIC INSURANCE INFORMATION

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

First Name Last Name

Name of Patient:		Date of Birth:	
Name of Subscriber:		Date of Birth:	
Subscriber's Address:			
Relationship to Patient:			
Subscribers SSN#:		Telephone:	
Employed by:			
Insurance Company:		Policy #:	
Insurance Telephone:		Group #:	

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

Name of Subscriber:		Date of Birth:	
Relationship to Patient:			
Subscriber's Address:			
Subscriber's SSN#:		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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