

***Dental
Insurance Eligibility Questionnaire***

In order to help you determine your orthodontic insurance benefits, please call your insurance company prior to your first visit and complete this form. Please bring the completed form to your first visit.

Patient's Name _____

Responsible Party's Name _____

Responsible Party's Employer _____

Insurance Group # _____

Social Security# or Insurance I. D. # _____

Responsible Party's Date of Birth _____

Name of Dental Insurance Company _____

Dental Insurance Company Address _____

Dental Insurance Company Phone # _____

The following important questions should be asked of the insurance company prior to the patient's first orthodontic visit:

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| 1. Is the patient covered by orthodontic insurance? | Yes | No |
| 2. Can you use an independent provider?
(We are a NON-network provider) | Yes | No |
| 3. Is there an age limit for children or students? | Yes | No |
| 4. Is adult coverage available (if applicable)? | Yes | No |
| 5. What is the effective date of the policy? _____ | | |
| 6. What is the remaining balance of the lifetime maximum benefit? _____ | | |
| 7. At what percentage of the total contract is the benefit paid? _____ | | |
| 8. Is there an annual or one-time orthodontic deductible? | Yes | No |
| 9. If so, what is the amount? _____ and has it been met? | Yes | No |

Insurance benefits will be paid by the insurance company directly to you.

Please inform the insurance coordinator immediately should there be any changes to the insurance benefits during the course of orthodontic treatment.

Signature _____ Date _____

Printed Name _____