pitts orthodontics

Today's Date _____

Patient Name _____

Patient's relationship to insured

- **Self** ☐
- **Spouse** ☐
- **Child** ☐
- **Other** ☐

Patient's Birthdate ____/____/____

If a full time student:

school _____ **city** _____

Insurance Carrier Name and Address:

_____

_____

_____

_____

Phone _____

Subscriber (employee) name and mailing address

_____

_____

_____

_____

Phone _____

____-____-____

Subscriber Social Security Number

_____

Subscriber id number (if not ssn)

____/____/____

Subscriber's Birthdate

Employer or Group Name _____

Group Number _____

I hereby authorize the release of any information relating to the orthodontic treatment of _____ **in order to bill my insurance for such services.**

X _____

Signature of patient or parent if minor

I hereby authorize payment directly to Pitts Orthodontics of the group insurance benefits otherwise payable to me.

X _____

Signature of insurance subscriber

Office use only

Spoke to _____

Primary/Secondary

Who do you pay?

Coordination of Benefits:

Lifetime Max:

Calendar Year Max:

Benefits paid over ____ months/auto Y/N

Percentage:

Eligibility Date:

Age Limits:

Preauth required?

Any benefits used?
Remaining Benefits:

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