



ellingsen • paxton • johnson
orthodontics

In order to assist you in determining your orthodontic benefits, please complete Sections 1 and 3

Section 1

Name of Patient: _____ Date of Birth: _____
Name of Insured: _____ Date of Birth: _____
Address of Insured: _____
Social Security #: _____ Telephone #: _____
Policy or group #: _____ Insured ID#: _____
Employer Name: _____ Telephone #: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Telephone # _____ Primary or Secondary?

-section 2 for office use only-

Date Checked: _____	Checked by: _____	Contact Person: _____
Max Ortho Coverage: \$ _____		
Lifetime -or- Yearly paid @ _____ %		
Deductible: \$ _____ (A/L) Been Met? _____		
Age Limit: _____		
Amount Used to Date? _____		
Pre Auth Required: _____		
Do you Pay an Initial Banding Fee? _____		
Benefit paid: Monthly / Quarterly / 2 Pay / Annual / Other	Benefit Paid? _____	P / S _____
We Bill -or- Auto if Secondary Coverage, How is Benefit Paid? _____		

Section 3: Complete the following if patient is covered under another dental plan:

Name of Patient: _____ Date of Birth: _____
Name of Insured: _____ Date of Birth: _____
Address of Insured: _____
Social Security #: _____ Telephone #: _____
Policy or group #: _____ Insured ID#: _____
Employer Name: _____ Telephone #: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Telephone # _____ Primary or Secondary?

-section 4 for office use only-

Date Checked: _____	Checked by: _____	Contact Person: _____
Max Ortho Coverage: \$ _____		
Lifetime -or- Yearly paid @ _____ %		
Deductible: \$ _____ (A/L) Been Met? _____		
Age Limit: _____		
Amount Used to Date? _____		
Pre Auth Required: _____		
Do you Pay an Initial Banding Fee? _____		
Benefit paid: Monthly / Quarterly / 2 Pay / Annual / Other	Benefit Paid? _____	P / S _____
We Bill -or- Auto if Secondary Coverage, How is Benefit Paid? _____		

Treatment Type: _____ Treatment Fee: _____ Treatment Time: _____
Class: _____ Initial Visit: _____ Start Date Sched: _____