Marcus Orthodontics
Specialist In Orthodontics

PATIENT NAME: ______________________________

DATE: ____________________ ❑ **UPDATE?**

ORTHODONTIC INSURANCE INFORMATION

We are happy to process your insurance claim for orthodontic treatment. In order to assist you with your insurance claim, please complete and sign this form.

	PRIMARY CARRIER *	SECONDARY CARRIER
Name of Insured		
Social Security Number		
Birth Date*		
Relationship to Patient		
Employer or Union		
Group Policy Number		
Insurance Company		
Insurance Company's Address		
City, State, Zip Code		
Telephone		
Signature		

*Person with the earliest birthday in the year is the primary carrier.