Orthodontic Insurance Information

James D. Campbell DDS, MS, PA

Insurance Company Information
Name____________________________________
Address__________________________________
(City, State, Zip)___________________________
Phone________________________ Group Number_________________

Patient Information
Name___________________________________
Date of Birth___________________ Age______ Sex: Male_____ Female_____
Is patient a full time student? ________
Relationship to Insurance Subscriber (employee):
Self_______ Spouse______ Child_____ Other______

Employee/Subscriber Name _________________________________
Address_____________________________________
(City, State, Zip)______________________________
Social Security Number_________________________

Employer (company) Name__________________________________
Address_____________________________________
(City, State, Zip)______________________________

Is patient covered by another dental plan? _______ If yes, Please provide:
Employee/Subscriber Name _________________________________
Social Security Number_________________________
Employer (company) Name__________________________________
Address_____________________________________
(City, State, Zip)______________________________

I authorize the release of any information relating to this claim:

____________________________ ____________
Signature (patient, or parent) Date

I hereby authorize payment directly to Dr. James D. Campbell:

____________________________ ____________
Signature (Insured Person) Date