Fey & Grey Orthodontics, PLLC

18807 Beardslee Blvd * Suite #101 * Bothell, WA 98011 - (425) 485-9633

ORTHODONTIC INSURANCE INFORMATION

In order to assist you in determining your orthodontic benefits, the following information is necessary:

Name of Patient: _____ Date of Birth: _____

Name of Insured: _____ Date of Birth: _____

Address of Insured: _____

Soc Security # or ID #: _____ Telephone #: _____

Employer Name: _____ Telephone #: _____

Dental Insurance Company: _____ Group #: _____

Insurance Company Address: _____

Insurance Company Telephone #: _____ Primary or Secondary? _____

~for office use only~

date chkd: _____ chkd by: _____ contact person: _____

LTM: $ _____ year / lifetime paid at: _____ % deductible: $ _____

age limit: _____ need to pre-authorize? _____

amount used to date? $ _____ does plan pay banding fee? _____

how is benefit paid? monthly/ quarterly/ 2 pay plan/ annual/ other we bill ~or~ auto

if coverage is secondary, how is benefit paid? _____

comments: _____

_____

electronic payer ID #:

Is patient covered under another dental plan? If so, please complete the following information:

Name of Insured: _____ Date of Birth: _____

Address of Insured: _____

Soc Security # or ID #: _____ Telephone #: _____

Employer Name: _____ Telephone #: _____

Dental Insurance Company: _____ Group #: _____

Insurance Company Address: _____

Insurance Company Telephone #: _____ Primary or Secondary? _____

~for office use only~

date chkd: _____ chkd by: _____ contact person: _____

LTM: $ _____ year / lifetime paid at: _____ % deductible: $ _____

age limit: _____ need to pre-authorize? _____

amount used to date? $ _____ does plan pay banding fee? _____

how is benefit paid? monthly/ quarterly/ 2 pay plan/ annual/ other we bill ~or~ auto

if coverage is secondary, how is benefit paid? _____

comments: _____

_____

electronic payer ID #:

I hereby authorize release of any information relating to this claim.

_____ Date: _____

Signature

I hereby authorize payment of insurance benefits directly to the above named orthodontists.

_____ Date: _____

Signature

Please notify our office of any changes in your insurance policy as soon as possible, thank you.