NAHAS AND DONAHUE ORTHODONTICS

GEORGE H. NAHAS, DDS
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ORTHODONTIC SPECIALISTS

WELCOME TO OUR OFFICE!

Please take a moment to complete the following so that we can better serve you!

ORTHODONTIC INSURANCE INFORMATION FORM

PRIMARY ORTHODONTIC INSURANCE

Patient Name _____Patient Birthdate _____
Insurance Holder Name _____
Relationship to Patient _____
Insured Social Security # _____ Insured Holder Birthdate _____
Full Address _____
Employer _____
Home Phone # _____ Business Phone # _____
Insur Co Name _____ Insur Co Phone #_____
Insur Co Full Address _____
Subscriber # _____ Group #_____

ADDITIONAL ORTHODONTIC INSURANCE

Patient Name _____ Patient Birthdate _____
Insurance Holder Name _____
Relationship to Patient _____
Insured Social Security # _____ Insurance Holder Birthdate _____
Full Address _____
Employer _____
Home Phone # _____ Business Phone # _____
Insur Co Name _____ Insur Co Phone # _____ _____
Insur Company Full Address _____
Subscriber # _____ Group # _____

AUTHORIZATION

I authorize my insurance company to pay *Nahas and Donahue Orthodontics* all orthodontic benefits otherwise payable to me for services rendered.
I authorize the use of the undersigned signature for all insurance submissions. I authorize *Nahas and Donahue Orthodontics* to release any information necessary to process and secure the payment of benefits. I understand that I am financially responsible for any charges not paid by insurance, including those charges that may be incurred by a change in, or loss of, insurance benefits.

SIGNATURE _____ DATE _____