Patient Name:_____ Insurance Verification

	Primary Insured	Secondary Insured
Subscriber's Name		
Subscriber's DOB		
Subscriber's Employer		
Subscriber SS# or ID#		
Insurance Co.		
Insurance Co. Address		
Insurance Co. Phone#		
Orthodontic Ins. Y or N		
Lifetime Max		
% Payable		
Non Duplicating		
Age Limitation		
Adult Coverage		
Method of Payment: Quarterly Monthly Every 6 months Half now;half later		
Assignment of Benefits Y or N		