

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.

Signature Date: _____

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

Signature Date: _____

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