DENTAL INSURANCE INFORMATION

If you'd like us to accurately determine your orthodontic benefits and/or submit a claim to your insurance, the insurance information below must be filled out completely.

Patient Name: ____ DOB: _____________________

Main Subscriber's Name: _______________________________________ DOB: ______________________

Relationship to Patient: Self Other: ___________________________

SSN: ____________________________ and Group ID # ________________________________

Employer's Name: ____

Member/Subscriber ID # ____

Insurance Name: ____

Phone # ____
(Located in the back side of your card)

Insurance Address ____
(Located in the back side of your card)

City: ___________________ State: ______ Zip: ___________________

STROUSE & WEXLER ORTHODONTICS
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